First Annual Report for the Tangiraneza "Start Well" Innovation CSP World Relief Rwanda

Nyamagabe District, Rwanda

October 2011-September 2015

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Field Partner: Rwandan Ministry of Health

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Acronyms

ACT	Artesunate Combined Treatment (Coartem)
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
ASM	Agente de Santé Maternelle (Maternal Health Agent)
BCC	Behavior Change Communication
CATCH	Core Assessment Tool on Child Health
CBN	Community-Based Nutrition
CBNP	Community-Based Nutrition Program
CCM	Community Case Management
CDC	Community Development Committee
CHW	Community Health Worker
C-IMCI	Community-Integrated Management of Childhood Illness
COSA	Health Committee (*Comite de Sante*)
CMAM	Community Management of Acute Malnutrition
CSHGP	Child Survival and Health Grants Program
DDP	District Development Plan
DIP	Detailed Implementation Plan
DPM	District Plan to eliminate malnutrition
EIP	Expanded Impact Child Survival Project
FE	Final Evaluation
FY	Fiscal Year
GMP	Growth Monitoring and Promotion
GoR	Government of Rwanda
HBM	Home-Based Management (of fever)
HC	Health Center
HFA	Health Facility Assessment
HMIS	Health Management Information System
HO	Home Office (WR term)
HSSPII	Health Sector Strategic Plan II
IFA	Iron-Folic Acid
IGA	Income-generating activities
ICG	Integrated Care Group
IMCI	Integrated Management of Childhood Illness
IMU	Inpatient Malnutrition Unit
IR	Intermediate Result
IYCF	Infant and Young Child Feeding
LLIN	Long Lasting Insecticide Treated Bed Nets
LOE	Level of Effort
KPC	Knowledge, Practice and Coverage survey
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program

MDP	Millennium Development Goals
MINAGRI	Ministry of Agriculture
MINALOC	Ministry of Local Government
MNC	Maternal and Newborn Care
MNCH	Maternal, Newborn and Child Health
M&E	Monitoring and Evaluation
MOH	Rwandan Ministry of Health
MOU	Memorandum of Understanding
MTE	Midterm Evaluation
MUAC	Mid-Upper Arm Circumference
OR	Operations Research
ORS	Oral Rehydration Solution
OTP	Outpatient Therapeutic Program
PD Hearth	Positive Deviance/Hearth model
PDA	Personal Data Assistant
PBF	Performance Based Financing
POU	Point-of-use
PVO	US Private Voluntary Organization
QA	Quality Assurance
RDHS	Rwanda Demographic & Health Survey
RDT	Rapid Diagnostic Test (for malaria)
RFA	Request for Applications
RIDHS	Rwanda Interim DHS
RT	Round Trip
RUTF	Ready to Use Therapeutic Food (Plumpy Nut)
SBC	Social and Behavior Change
SMS	Short Message Service (text message)
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAS	Vitamin A Supplement
WHO	World Health Organization
WR	World Relief
WRA	Women of Reproductive Age

A. Main Accomplishments

The Innovation CSP successfully completed the first year, largely due to the experienced and hardworking staff of CSP Promoters, overseen by Melene Kabadege (WR Regional Technical Advisor), and led by Carmen Umutoni, the CSP Director. The first year went relatively smoothly, despite some unanticipated extra work related to the Operations Research (OR), such as a double KPC. WR Home Office technical unit staff helped by writing the OR Concept paper and with the Nutrition Week curriculum development.

The WRR Kigali office supported the CSP in setting up the Nyamagabe District Project office: hiring, orienting and training staff and establishing reporting and financial systems. WRR staff have been working with the District MOH staff since before the program began for a smooth start-up, which was possible because of the existing relationships developed during the previous work with the Expanded Impact CSP from 2007-2011.

From November 2011-February of 2012, WRR staff (particularly Melene Kabadege and WRR Director of Programs Maurice Kwizera, and Country Director Myal Greene) endeavored to obtain approval for the operations research from the Rwanda Ethics committee. This required a prior meeting with National-level MOH staff to present the Operations Research project, which resulted in two key MOH National staff becoming study Co-Investigators. This connection should facilitate uptake of successful elements of Nutrition Weeks. On February 11, 2012 WR presented the OR to the Rwanda Ethics Committee, who approved the Operations Research.

From January-May of 2012 the CSP team developed and conducted baseline assessments. The qualitative studies were two separate 30-cluster KPC surveys: one for the intervention area in Kaduha hospital zone, and one for control area in Kigeme hospital zone. WR also completed were a literature review for the OR study, qualitative surveys (such as the doer/non-doer analysis) and the DIP. Facilitating factors include WRR staff extensive field experience, WR HO technical unit staff expertise, and nutrition expertise shared by Judy Mclean and her University of British Columbia research assistants who assisted with KPC and formative research data analysis for the DIP. Also, MCHIP in Rwanda lent WRR their Smartphones for KPC data collection; MCHIP staff set up database in smart phones and facilitated a training for surveyors on use of smart phones.

The CSP officially began fieldwork with training for WR and MOH staff during the orientation meeting on Care Groups (the first intervention) on June 5 to 11, 2012. Previous collaboration with MOH during EIP helped this go smoothly.

From May- August 2012, WRR and WR Home Office staff developed the Nutrition Weeks Curriculum for training MOH staff, CHWs, and mothers in community. This was facilitated by technical input from Judy Mclean (the Primary Investigator), Judiann McNulty (a consultant), Melene Kabadege, and Olga Wollinka of the WR HO technical unit (who has experience with WR PD/Hearth programs). Of additional help were technical documents such as the 2009 TIPS Report on feeding practices and beliefs in Rwanda. The Nutrition Weeks pilot began in September, and Judy Mclean was able to visit the first sessions in September 2012).

Some other key accomplishments (more described in section J) include:

- The Rwanda Nutrition Technical Working Group (NTWG) requested that CSP staff lead workshops to develop a curriculum on Cooking Demonstrations that will be used by MOH nationwide.
- The CSP was delegated by the MOH to supervise the National Campaign for Community Mobilization on Nutrition through *Umuganda* in *Nyamasheke* District in December 2011. *Umuganda* is a village level community service program held on the last Saturday of each month. Tasks include cleaning roads, building schools, etc. After the work time there is a meeting to discuss issues such as health, security, and development. This December meeting was planned by the MOH to mobilize community members to improve nutrition countrywide.
- The successful creation of 536 Care Groups via collaboration among CSP staff, Local leaders, Health Center leaders and Religious Leaders.
- The CSP collaborated with the District to lead the election of CHWs in the Refugee Camp (recently created in Nyamagabe district) and with Kigeme Hospital to distribute SOSOMA flour to refugees.
- Maternal exit interviews from the first Nutrition Weeks pilot displayed a considerable amount of appreciation for the new behaviors learned, even asking to extend nutrition week to 7 days in the future. The mothers also independently proposed to meet once a week in order to review the lessons of NW after it concluded, further highlighting the impact NW had on mothers. The considerable positive response advocates for the scaling up of this approach to reach more mothers in the district.

M&E plan status of completion as of October 2012.

Baseline and Final Evaluations and Household Surveys: 30-cluster KPC surveys will be conducted annually to determine project performance using KPC 2000+ modules that include the 2008 Rapid CATCH (Core Assessment Tool on Child Health) indicators. **COMPLETED** Survey and evaluation teams included MOH staff and other stakeholders. Results of the surveys and formal evaluations were disseminated to community and MOH stakeholders in order for all parties to understand the health status of the population, and contribute to achievement of objectives. **COMPLETED**

Operations research: Baseline surveys included OR data collection needs. WRR received approval from the National Ethics Committee before implementing research activities in communities. **COMPLETED**

Qualitative formative research: WR trained staff and MOH partners in qualitative data collection methods and use of the Designing for Behavior Change Framework during EIP. As WRR had already designed and tested messages adopted nationally for BCC on C-IMCI during EIP, this CSP's qualitative formative research focused on development of content and materials for Nutrition Weeks. Focus groups and in-depth interviews will also be used as a management tool to better understand trends in quantitative data that require explanation. In addition, every Care Group meeting provides informal opportunities for community-level feedback and increased understanding of local belief systems. If there is a lack of consensus, the members can be asked to query their neighbors before the next meeting**. COMPLETED and ONGOING**

Barriers to optimal practices will be discussed in Nutrition Weeks meetings, on home visits, and through exit interviews with mothers and CHWs after NW sessions. Also, CHWs will hold pre-Nutrition Week community meetings with families in the village, explaining the program to them. **ONGOING**

Challenges: The first Nutrition Week session had fewer fathers attending than hoped for, and in some instances mothers in law attended on days that were for father involvement. The project will focus on improved communication and working with local leaders to improve fathers' involvement.

Qualitative methodologies include exit interviews of mothers and post-NW interviews with CHWs, MOH staff, and CSP staff. This information will be used to refine the design for the next Nutrition Week. For baseline surveys, staff will conduct Positive Deviance Inquiries (PDI) and doer/non-doer analyses. Each cycle of NW will collect and analyze exit interviews and the CHW home visits for effectiveness in changing behaviors. **COMPLETED and IN PROCESS**

Current MOH Community Data Collection: CHWs track and report on a number of indicators that get reported into the MOH's health information system. CHWs responsible for CCM maintain treatment registers for children treated in the community and/or referred to health centers. They also maintain a register for growth monitoring and referrals of suspected moderate and severe acute malnutrition cases. Likewise, CHWs responsible for maternal and newborn care maintain registers that track pregnant women from the time pregnancy is suspected through the delivery and post-natal period. Summary data from these registers is compiled jointly by the CHWs on a monthly basis and submitted to the health center in the form of a joint monthly report. The current form used by the MOH for monthly reporting includes data on vital events, all MNCH and nutrition coverage, and processes like supervision visits, CHW community meetings, etc. The tool additionally tracks community stocks of family planning commodities, artesunate combined treatment (ACTs), zinc, ORS, amoxicillin, mebendazole, Sur'Eau point of use (POU) water treatment, Vitamin A, long lasting insecticide-treated nets (LLINs) and tuberculosis (TB) drugs. The data presently get communicated from village to cell to sector to health center/cooperative to District Hospital to District to National Level. **COMPLETED**

Challenges: August 2012 CHW data showed a difference in reported deaths between Kigeme and Kaduha; Kaduha reporting a normal rate of under 5 deaths but Kigeme zone reporting none, which is unlikely. The CSP Director is following up to discover the reasons for this. Also, it has been noted that the extensive CHW Health information system can be overwhelming, so the WR Regional Technical Advisor is working on streamlining the reporting.

Shift to Electronic CHW reports. The MOH plans to shift from pencil and paper reporting to having CHWs submit their reports electronically via a mobile phone interface. The transition will include a period of time with both reporting mechanisms while CHWs become proficient in the new method. The project has budgeted to support MOH training for CHWs in the use of cell phones for data reporting. "Rapid SMS" is another mobile phone-based reporting methodology the MOH is beginning to use with CHWs working in maternal health to enable CHWs to summon emergency transport and receive timely feedback from health center staff in the event of maternal or newborn danger signs. CHWs will eventually track weight using rapid SMS. **COMPLETED and ON TARGET, yet with some challenges.** CHWs have been reporting data

using Rapid SMS. In July 2012, WR/ICSP conducted refresher training to 534 ASM on Rapid SMS. However, MOH August statistics show that only 30% of CHWs in Nyamagabe use SMS reporting. According to the CHW Supervisors at the Hospitals, the MOH central level has sometimes misidentifies a CHW, leading to incorrect data input.) Another problem is that CHWs lose their cell phones.

Complementary Community Data: As the MOH does not collect information on household-level behavior change, WR will use the community mobilization tracking system developed in EIP, with minor modifications to reflect greater emphasis on nutrition and maternal and newborn care. This system tracks CHWs, their work, and outputs such as handwashing stations, numbers of people reached via educational sessions, etc. In addition to using said data for management purposes, World Relief shares results from its tracking system with health centers and district hospitals and authorities. However, because these data are not part of the MOH health management and information system (HMIS), they do not get officially incorporated, nor do they factor into payment for community performance based financing. WR will continue to advocate for key community indicators on behavior change to be included in the formal HMIS and performance-based financing (PBF) package, to help focus attention on effective community mobilization for household behavior change. **ON TARGET**

Table 1. September Care Group data collected from Care Group community mobilization meetings, by topic and with total number of beneficiaries (data gathered from 5 sectors.)

Topic of community education	Male	Female	TOTAL
Mosquito net use	9,421	10,732	20,153
Handwashing	9,760	15,580	25,340
Proper use of good latrines	8,632	12,004	20,636
Hygiene	8,632	12,004	20,636
Nutrition for lactating and pregnant women	10,523	18,956	29,479

CHW Performance: The MOH has a system for annual evaluation of CHW performance as part of an evaluation of community level service provision. WR has been asked to participate in these evaluations, and has budgeted as such. The planning and content of refresher trainings for CHWs is typically based on the findings of these evaluations. The MOH plans to add MNCH in the District so this project also anticipates CHW evaluation on MNCH and BCC.
COMPLETED for 2012 and ongoing annually

Organizational Performance: The Project Manager and Officers meet monthly to discuss results and challenges. These meetings are opportunities for quality improvement as staff identify and define problems, establish desired outcomes and plan steps to achieve them. The CSP will organize quarterly meetings for District Hospital and Health Center leadership to coordinate activities and share feedback on results. Other NGOs or other partners working in related areas also will be invited to attend. There will also be feedback meetings to support CHW cell coordinator in their role of aggregating data from the villages, the project will build the capacity of Data managers and CHWs In-Charge related to management of community data and to check for data quality. We have budgeted for both of these activities. **COMPLETED and ONGOING**

B. Activity Status

Table 2: Project Activity Status

Project Objectives and Results	Related Key Activities	Status of Activities
Technical (Nutrition, Maternal and Newborn Care, Diarrhea, Pneumonia) *Please see DIP for details on program activities for each intervention, as space does not allow a replication of that information here.*	DIP preparation	Complete
	Participate in Nutrition Technical Working group and solicit input for NW curriculum development. Feedback from the Nutrition technical working group included the suggestion to make NW three times per year (instead of twice), and a few other points related to working with CHWs and MOH staff. (Please see Annex 4 for the feedback from the Nutrition Technical working group.)	Complete
	Operations Research protocol developed, approval granted by the Rwanda Ethics Committee, and Nutrition Weeks curriculum developed.	Complete
	Conduct Training of Trainers (TOT) for CHWs (binome- both male and female volunteers) on Maternal Infant and Young Child Nutrition (MIYCN) (June 12-28, 2012)	Completed
	TOT for Maternal and Newborn Care package June 25-30, 2012. Then, training of ASM on the Maternal and Newborn Care package (July 9-21, 2012.) The DIP refers to this as building health center and hospital staff capacity to train ASM on MNC and rapid SMS.	Completed
	In Intervention areas, train MOH trainers and In-charge of Social Affairs on Nutrition Weeks innovation.	Completed
Capacity-building	Build MOH and Sector Social Affairs In-Charge capacity to train and supervise BCC activities. (Refresher training planned for 2013.)	Completed
	Train CHW Cell Coordinator and In-Charge of Social Affairs at cell-level to supervise CG in Interventions and BCC. (TOT/supervisors on Modified Care Group July 14-17, 2012.	Completed
	Training of Modified Care Group leaders on BCC activities July 22-28, 2012.)	Completed
	Quarterly meetings with Local Leaders and religious leaders on BCC.	On target
Sustainability	Care Group formation and quarterly meetings for CG Leaders and Supervisors. (Care Group Leaders lead monthly integrated CGs) and follow-up on CG BCC activities)	On Target
	Mobilize churches to assist needy households with kitchen gardens and tippy taps. This was done July 18-19 2012 through the meetings with Religious Leaders.	Completed

Table 3. CSP Staff Training and development

Training Topics	Trainees	Date	Site
Master training on MIYCN	Nutrition Officers	December 19-23, 2011	*Musanze District*
BCC: Community action cycle	Community Mobilization Officers	June 20-21, 2012	*Kigali*

Master training on SIS com; Rapid SMS, *Mubuzima* & CHW financial Cooperatives	M&E Officers	June 12-15, 2012	*Kigali*
Training on Team work building	All CSP staff	February 27-28, 2012	Nyamagabe CSP Office
Training on report by USAID mission	M&E Officers	July 25, 2012 & August 9, 2012	*Kigali*
Training on KPC survey	All staff	March 28-30	*Kigali & Nyamagabe District*
TOT on Rapid SMS, SIS Com& CHW Financial Cooperatives	M&E Officers	August 21-25, 2012	*Huye District*

C. Factors that are impeding/ facilitating progress to date

Obtaining approval for Operations Research from the Rwanda Ethics Committee was a long process, and a recent policy change requiring MOH approval *before* going before the committee delayed approval (and thus the KPC) by one month. WR was granted a 2 week extension on the DIP, which was a help. The MOH is a strong partner and two Rwandan MOH staff have volunteered as Co-Investigators: **Dr Fidele Ngabo,** MD, MSc, PhD Candidate, Director of Maternal and Child Health Unit and **Alphonsine Nyrahabineza**, Head of Nutrition Desk. Please see annex 8 for the letter of support from Dr. Fidele Ngabo of the MOH.

D. Technical Assistance

Technical Assistance in nutrition is being provided by Judy McLean, the Primary Investigator, who will visit Nyamagabe every year, most recently in September 2012. In addition to reviewing the NW curriculum, she has helped with development of the OR concept paper, reviewing the DIP and also with data analysis from the baseline surveys. The Department of International Nutrition at University of British Columbia has also provided research assistants to assist with OR and documentation of the project (so far, Molly Newman helped with the Rwandan Ethics Committee presentation and KPC analysis, Kristina Michenaux spent 2 weeks in April helping with data analysis, and Jessalyn Shamess visited in October to help with the OR documentation (see the recently signed MOU between WR and UBC in annex 7.) Dr. Judiann McNulty, who has extensive experience with the PD/H model and NGO nutrition programs (as well as advanced degrees in nutrition and public health) has provided feedback on the NW curriculum and the workplan, and retains a strong interest in the project. Dr. Gretchen Berggren has provided technical support as she and Dr. Warren Berggren know Rwanda from when WRR had them provide a workshop on PD/H for an earlier WRR CSP.

E. Changes to the DIP

Although there are no substantial changes to the project description from the DIP, WR was asked to expand various sections, so **a revised DIP is being submitted along with this report**.

F. Progress towards sustainability plan

This CSP was designed to achieve real gains in health and nutritional status, and to sustain them by training and supporting local MOH staff as well as developing local integrated Care Groups of volunteers taken from a cross-section of Rwandan village leadership. Key activities that build competency of MOH staff are on target, and as the previous CCM project (Expanded Impact Program) also worked with MOH to help them directly support Care Groups, both WRR staff and the MOH are accustomed to this model and the expectations for local sustainability.

Melene Kabadege, who has 12+ years of CSP experience and working with MOH staff, is particularly optimistic about the viability, effectiveness and sustainability of Village-level Integrated Care Groups compared with the larger geographical focus of Cell-level Care Groups of CHWs from the previous EIP. Modified Care Groups that integrate village leaders and community health workers should be more effective because both of these groups have been given responsibility from the government of Rwanda to mobilize community members.

The CSP did not formally use the CSSA Framework for this Annual report, although its dimensions and components are part of the plan. For example, health outcomes, local capacity and community capacity are all significant factors that have been taken into account.

G. Response to the DIP consultation

The DIP review and the subsequent letter of August 3, 2012 requested the following changes:
The DIP needed to be expanded to incorporate the discussed responses and revisions from the feedback received prior to the DIP review meeting, including changes to the results framework presentation and a description of linkages to agricultural interventions and commodity requirements. In addition, expand on the qualitative portion of the M&E plan and plans for non-project staff capacity development that extend beyond training activities. Additional Information on the project's Behavior Change Strategy would be useful.
This has been done in the revised DIP submitted along with this annual report.

The Operations Research (OR) design and description needs to be strengthened; submit the revised version of the OR Protocol as agreed in the meeting for review by the MCHIP and CSHGP teams. In particular, include a more in-depth description of the formative research to be conducted by the project and proposed quality of implementation indicators. Please submit a revised, final DIP and OR Protocol, with the above changes, on or before October 30, 2012. Please include with your submission changes that respond to MCHIP's previous feedback.
The revised DIP and revised OR Protocol have been submitted with this Annual Report as two additional separate documents, with incorporated changes. Please see Annex 3 for the Project's Social and Behavioral Change strategy that was requested during the DIP review.

H. First year and Innovation Grant updates and Social and Behavior Change Strategy

Please see annex 3 for the Behavior Change Strategy paper. Please see Annex 4 for Annual update on progress of the Operations Research study documentation.

I. Management system update

There have been no changes to the **management system** since the submission of the DIP. The Financial management system is run by WRR and WR Home Office and there have not been any problems. Human resources have been sufficient, although the first year was taxing to WR Home Office technical staff, as writing the OR Concept paper and all the work related to the OR was significant. It has been helpful for WRR to have had several interns (both MPH and UBC International Nutrition graduate students) to work on English reports documenting the NW model development. The Communication system and team development are satisfactory. Local partner relationships have been somewhat challenging, as the National MOH several times has asked WRR to make adjustments to the project interventions based on other grants that they are getting from other donors. These requests have been dealt with by WRR management staff, and in some cases, by Patrick Condo of the USAID Mission. PVO coordination/collaboration in country goes well, and WRR has always been involved with other NGOs (such as when WRR brought in Drs. Warren and Gretchen Berggren to hold a workshop on PD/Hearth, and MOH and other NGO staff were invited to participate). Judy Maclean visited one of the first Nutrition Weeks pilots in September, which was very opportune.

Maurice Kwizera, WRR Director of Programs comments: The project has not experienced any particular challenges in the management system. In human resource development, WRR proactively conducted a two day training session on team-building, aimed at improving the cohesion and effectiveness of the project team. In order to increase speed of fund transfers to project field office, World Relief Rwanda upgraded the old system with bank paperwork, and now the Finance Manager is able to immediately credit the project account using online transfer from World Relief Rwanda main office in Kigali.

J. Local Partner Organization Collaboration and Capacity Building

Training and capacity building of MOH, local leaders and religious leaders is key to the implementation of the CSP, and has proceeded according to plan, see table below.

Table 4. Capacity Building of MOH, local leaders, and religious leaders

Training Topics	Trainees	Male	Female	Date	Site
Training for 19 MOH enumerators on KPC survey for four days	Hospital Data Manager HC Data Manager In Charge of Community Health/Hospital level In charge of Community Health/HC Level	10	9	March 28–30, 2012 April 2, 2012	Kigali Nyamagabe District
Training for 564 CHWs binomes of Kaduha Hospital Zone on MIYCN for 5 days	CHS (Binomes)	282	282	June 6-22, 2012	Nyamagabe District
Training for 70 HC trainers/Supervisors on Care Group and BCC for one day	In charge of Community Health/HC Level Heads of HC In charge of Social Affairs	49	21	August 14,16,17, 2012	Nyamagabe District
Training for 534 CG Leaders on CG & BCC	CHWs Head of Villages	237	297	August 22-23, 2012	Nyamagabe District

methodology for 2 days					
6 day-TOT on MNC for 28 MOH staff	In Charge of CHWs Nurse, Environmental Health Officer M&E Officer/ Hospital Level	9	19	June 25-30, 2012	Nyanza District
Training for 534 ASM on MNC for 6 days	CHWs (ASM)	534		July 9-21, 2012	Nyamagabe District
Master training (Orientation Meeting) on NW for one day	In Charge of Community Health/Hospital level, M&E Officer/District Nutritionist/Hospital level	1	3	September 10, 2012	Kaduha Hospital
TOT on NW at HC level for 3 days	In charge of CHW/HC Level In charge of Social Affairs /Sector Level In charge of Social Affairs/Cell Level Nutritionist/HC level	11	27	September 12-14, 2012	Musebeya Sector
Training for five Village Nutrition Committees on NW for three days	CHWs Head of Village In charge of Social Affairs at Village level	13	12	September 18-20, 2012	Musebeya Sector/ Rusekera Cell
Meeting with Religious Leaders to mobilize the on Behavior change strategy	41 Religious Leaders	36	5	September 18-19, 2012	Kaduha & Mushubi Sectors

Key activities showing CSP collaboration with Partners (MOH, District)

- CSP Nutrition Officers participated in the Nyamagabe District workshop for developing the District Plan to eliminate Malnutrition in October 2012.
- CSP staff provided Technical support to the MOH Training of Trainers session on Maternal and Infant and Young Child Nutrition (MIYCN) in May 2012.
- CSP staff participated in a one day workshop meeting organized by the Ministry of Health, Maternal and Child Health Unit/Community Health Desk in collaboration with Supply Chain for Community Case Management Project (SC4CCM) on June 29, 2012.
- As requested by the Rwanda Nutrition Technical Working Group (NTWG), CSP staff are leading workshops to develop curriculum on Cooking Demonstrations that will be used by MOH nationwide.
- CSP staff collaborated with the MOH and the District during the MCH National Campaigns. World Relief donated 500,000 tablets of Mebendazole used during the National MCH Campaign.
- CSP staff worked with the District and HCs to oversee local restaurant hygiene practices.
- The CSP was delegated by the MOH to supervise the National Campaign for Community Mobilization on Nutrition through *Umuganda* in *Nyamasheke* District in December 2011.
- The MOH provided two Co- Investigators to collaborate with CSP staff in the Operations Research component of the CSP (Nutrition Weeks).
- MOH/HC staff facilitated feedback meetings on M&E in collaboration with CSP staff.
- CSP staff have supported Nyamagabe district CHW supervision (both technical and financial support; the MOH needs help with budget for supervision).
- The successful creation of 536 Care Groups is due to collaboration among CSP staff, Local leaders, Health Center leaders and Religious Leaders.

- The CSP collaborated with the MOH to create a BCC tool during MOH workshops at Gisenyi, Kibuye.
- District leaders sent invitation letters to participants attending meetings or trainings organized by the CSP/ World Relief.
- The Medical Doctor Directors of the two hospitals collaborate with the CSP: they open and close the CSP training sessions and workshops, and provide follow up on topics covered.
- The In Charge of Community Health at Health Center and Hospital levels and the In Charge of Social Affairs at Cell and Sector levels collaborate with the CSP team to supervise Care Groups and Nutrition Week activities.
- The CSP collaborated with the District to lead the election of CHWs in the Refugee Camp (recently created in Nyamagabe district) and with Kigeme Hospital to distribute SOSOMA flour to refugees.
- Hospitals, Health Centers, District, and Sectors provide meeting space for CSP meetings and trainings free of charge.
- *Nyarusiza* Sector provided an agronomist to train mothers in Kitchen gardens after a Growth Monitoring session held in August 2012.
- The MOH invited CSP staff to participate in the assessment of DPM progress activities in *Nyanza, Gasabo, Nyarugenge and Karongi* Districts in June 2012. (DPM is the District Plan to Eliminate Malnutrition. It is a country wide plan whereby each District has a plan to eliminate malnutrition and it is included in the District performance contract. NGO partners are requested to support the DPN development plan in their District, and to support the implementation and to support the progress assessment.
- In collaboration with the MOH trainers, ICSP MNC Officers facilitated training for ASM on MNC package in eight districts: *Nyanza, Kamonyi, Ngoma, Kirehe, Gicumbi, Bugesera, Karongi & Rutsiro* Districts.
- Finalized an integrated Supervision tool during an MOH session in September 2012.

Collaboration with other NGOs
In May 2012, CCM Officers participated in CHWs (Binomes) performance assessment with MCHP (were involved in developing and testing questionnaire.) The CSP organized a meeting with stakeholders on Nutrition programming in Nyamagabe District.

Collaboration with religious Leaders
CSP staff identified 536 representatives from Churches to participate in monthly Care Group meetings, and to work with CGs in disseminating health messages. Also, the CSP works with Church leaders to help them share key health messages with their congregations.

K. Mission Collaboration

The CSP has engaged in collaboration with the Local USAID Mission through regular and open communication, and attending technical meetings organized by the mission. The Mission was kept in the loop on the process of signing the MOU with the Ministry of Health. (A copy of the MOU was shared with the Mission and we received appropriate feedback on areas of importance

of the MOU.) For all important email communications with the Ministry of Health or other key stakeholders, the project point person at the Mission is kept informed.

Several meetings took place with the Mission. They included routine quarterly USAID partners meetings for updates and experience sharing. One special meeting was purposefully organized to update the Mission on the progress of field activity implementation and receive feedback. The Mission facilitated and attended with the project staff a DIP review session remotely, organized in DC. The project staff was refreshed on the use of the USAID web-based training programs tracking and reporting system (TraiNet). For this reporting purpose, one M&E Officer was appointed from the project as point person and reports on trainings are regularly submitted.

Annexes

Annex 1: M&E Table

Table 5. M&E Table including Monitoring Data for October 2011-September 2012 RED indicates current data

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measure-ment Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 2011 – Oct 2012	EOP Target	Related Activities
	I. Breastfeeding and Nutrition (40% LOE)							
IR3	Improve breastfeeding practices	Immediate breastfeeding of newborns: Percent of children 0-23 months who were put to the breast within one hour of birth. (Key indicator MNC) (OR)	OR; MTE KPC, FE KPC	Annually	Kaduha 48.32% (CI: 43.14-53.50%)		70%	BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 51.1% (CI: 45.94-56.26%)		70%	
		Prelacteal feeding Percent of children 0-23 months given liquids prior to the initiation of breastfeeding.	OR; MTE KPC, FE KPC	Annually	Kaduha 10.99% (CI: 7.74-14.24%)		3%	BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 10.70% (CI:7.42-13.92%)		3%	
IR3	Exclusive Breastfeeding (tracking only)	Percent of children age 0-5 months who were exclusively breastfed during the last 24 hours. (RC)	OR; MTE KPC, FE KPC	Annually	Kaduha 91.11% (CI:85.23-96.99%) By age: 0-1m: 64.0% 2-3m: 86.2% 4-5m: 63.6% 0-3m:87.0%			BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 98.89% (CI:96.73-100.00%) 0-1m: 87.5% 2-3m: 96.8% 4-5m: 96.8% 0-3m: 98.2%			

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measure-ment Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 2011 – Oct 2012	EOP Target	Related Activities
IR3	Continued breastfeeding at 1 year (tracking only)	Percent of children 12-15 months who are still breastfeeding.	OR; MTE KPC, FE KPC	Annually	Kaduha 85.42% (CI:5.44-95.40%)			BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 93.44% (87.23-99.65%)			
	Continued breastfeeding at 2 years (tracking only)	Percent of children 20-23 months who are still breastfeeding.			Kaduha 86.79% (CI:77.67-95.91%)			
					Kigeme 90.91% (CI: 82.42-99.40%)			
IR3	Improve Infant and Young Child Feeding Practices	% infants and young children age 6-23 months fed according to the **Minimum Dietary Diversity** (OR)	OR; MTE KPC, FE KPC	Annually	Kaduha 21.85% (CI: 16.92-26.78%) By age: 6-11m: 0.0% 12-17m: 31.7% 18-23m: 40%		60%	BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 38.89% (CI: 33.08-44.70%) By age: 6-11m: 0.0% 12-17m: 50.6% 18-23m: 51.6%		55%	
		% infants and young children age 6-23 months fed according to the **Minimum Meal Frequency** (OR)			Kaduha 7.04% (CI: 3.99-10.09%)		55%	
					Kigeme 7.41% (CI: 4.07-10.21%)		60%	
		% infants and young children age 6-23 months fed according to the			Kaduha 2.96% (CI: 0.92-4.94%)		50%	

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measure-ment Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 2011 – Oct 2012	EOP Target	Related Activities
		Minimum Acceptable Diet *WHO 2008 definition (OR, RC*)			Kigeme 3.33% (CI: 1.19-5.47%)		50%	
IR3	Consumption of iron-rich foods	% infants 6–23 months of age who consumed food rich in iron. (Include micronutrient powders if/when program expands to Nyamagabe)	OR; MTE KPC, FE KPC	Annually	Kaduha 15.19% (CI: 10.91-19.47%)		50%	BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 23.33% (CI: 18.29-28.37%)		50%	
IR3	Age appropriate introduction of semi-solid foods	Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods.	OR; MTE KPC, FE KPC	Annually	Kaduha 52.00% (CI: 38.15-65.85%)		75%	BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 58.50% (CI: 45.23-71.77%)		75%	
IR3	Responsive feeding	Percent of Caregivers who assist child when eating (of children who consume soft, semi-solid or solid foods) (This indicator will get revised at next survey; will reference HF project data for baseline at that time.)	OR; MTE KPC, FE KPC	Annually	Kaduha 6.93% (CI:3.65-10.21%)		TBD	BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 13.08% (CI:8.97-17.37%)		TBD	
IR3	Self- Feeding (tracking only)	Percent of children who consume soft, semi-solid or solid foods) who are self-feeding			Kaduha 94.81% (CI:91.95-97.67%)			BCC through CG, Churches, Community meetings, Home visit & NW
					Kigeme 87.34% (CI: 83.11-91.57%)			
IR3	Vitamin A Supplementation in the last 6 months	Percent of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall. (RC 8, OR)	MCH week report OR report	Bi-annually	Kaduha 70.37% (CI:64.92-75.82%)			BCC through CG, Churches, Community meetings, Home visits NW; support to HC for MCH week
					Kigeme 77.04% (CI: 72.02-82.06%)			
	Anthropometry							
	Underweight for Age	Percent of children 0-23 months who are underweight (-2 SD for the	Monthly Growth Monitor-	Monthly Annually	Kaduha 17.8% (CI:14.00-22.50%)			BCC through CG, Churches,

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measure-ment Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 2011 – Oct 2012	EOP Target	Related Activities
IR3	(tracking only)	median weight for age, according to WHO reference population) Disaggregate underweight by moderate (≤-2SD and >-3SD) and severe (≤ -3SD) (RC)	ing, OR		Severe: 7.2% (CI: 4.8-10.8%) Moderate: 10.6%(CI:7.9-14.1%)			Community meetings, Home visit NW Counseling through GMP
					Kigeme 8.9% (CI:6.6-15.0%) Severe: 2.2% (CI: 1.2-4.2%) Moderate: 6.7%(CI:4.5-9.9%)			
IR3	Acute Malnutrition / Wasting (tracking only)	% children 0-23 months who are underweight for height (-2SD for the median height for age, according to WH0 reference population) Disaggregate wasting by moderate (≤-2SD and >-3SD) and severe (≤ -3SD) (OR)	OR	Annually	Kaduha 7.6% (CI: 4.9-11.6%) Severe 3.9% (CI:2.3-6.8%) Moderate 3.7% (CI:2.2-5.9%)			BCC through CG, Churches, Community meetings, Home visit NW Counseling through GMP
					Kigeme 6.1% (CI:4.1 -9.1%) Severe 2.2% (CI:1.1-4.6%) Moderate: 3.9% (CI:2.3-6.4%)			
IR3	Acute Malnutrition (tracking only)	Percent of children 6-23 months acutely malnourished as measured by MUAC Disaggregate by 'at risk', moderate and severe acute malnutrition	Monthly Growth Monitoring Report OR	Monthly Annually	Kaduha 8.3% (CI: 5.3-12.7%) 1.5% severe 6.8% mod. 18.52% at-risk	Kaduha 0.08 severe 1.97% mod. *(Screening August12)*		BCC through CG, Churches, Community meetings, Home visit NW Counseling through GMP
					Kigeme 5.2% (CI: 3.0-8.9%) 0.4% severe 4.8% mod. 20.37% at-risk	Kigeme 0.04% severe 1.61% mod. *(Screening August 12)*		

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measure-ment Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 2011 – Oct 2012	EOP Target	Related Activities
IR3	Stunting (tracking only)	Percentage of children under five years of age who are under height/length for age (-2SD for the median height for age, according to WHO reference population) Disaggregate stunting by moderate (≤-2SD and >-3SD) and severe (≤ -3SD)	OR	Annually	Kaduha 44.3% (CI:37.6-51.2%) Severe 25.1% Moderate 19.2%			BCC through CG, Churches, Community meetings, Home visit NW Counseling through GMP
					Kigeme 33.4% (CI:27.1-40.4%) Severe 12.5% Moderate 20.9%			
	I. Maternal & Newborn Care (35% LOE)							
IR1	Increase % of mothers who have 4+ ANC visits	% mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child. (RC1)	MT KPC Final KPC	Y3&4	Kaduha 45.5% (CI: 40.34-50.66%)		75%	Training ASM CHWs for MNC; BCC; household visit
					Kigeme 48.9% (CI: 43.74-54.06%)		75%	
IR1	Increase % of mothers who have ANC in their first trimester (tracking only)	% mothers of children age 0-23 months who had antenatal visit in the first trimester when they were pregnant with the youngest child	MT KPC Final KPC		Kaduha 54.5% (CI: 49.34-59.56%)			ASM training, BCC, household visit
					Kigeme 54.7% (CI: 49.56-59.84%)			
IR1	Increase % of mothers who get at least two TT	%mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child. (RC2)	MT KPC Final KPC ASM monthly report	Y3&4 Monthly	Kaduha 68.43% (CI: 63.58-73.22%)		80%	ASM training, BCC, household visit
					Kigeme 68.33% (CI: 63.49-73.11%)		80%	
IR1	Increase skilled birth attendance	% children age 0-23 months whose births were attended by skilled personnel.	MT KPC Final KPC ASM	Y3&4 Monthly	Kaduha 83.0% (CI: 79.11-86.89%)			ASM training, BCC, household visit

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measure-ment Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 2011 – Oct 2012	EOP Target	Related Activities
	(tracking only)	(RC3)	monthly report		Kigeme 91.7% (CI: 88.85-94.55%)			
		Percentage of mothers who deliver at Health Facility				Kaduha 92% 895/978 Kigeme 87% 847/978		
IR1	Increase % of newborns who get a post-natal check-up within 2 days of birth (RC 4)	% of mothers of children 0-23 m. whose youngest child received a post-natal visit from an appropriate trained health worker within 2 days of birth. (RC4)	MT KPC Final KPC ASM monthly report	Y3&4 Monthly	Kaduha 37.70% (CI: 32.68-42.72%) Kigeme 44.2% (CI: 39.07-49.33%)		60% 60%	ASM training, BCC, household visit
	Current Contraceptive Use Among Mothers of Young Children (tracking only)	% mothers of children 0-23 months who are using a modern contraceptive method. (RC5)	MT KPC Final KPC ASM monthly report	Y3&4 Monthly	Kaduha 57.5% (CI: 52.38-62.62%) Kigeme 62.5% (CI: 57.5-67.5%)			ASM training, BCC, community mobilization to use CBP
IR1	Increase iron-folic acid supplementation during pregnancy.	Percentage of mothers who received tablets; average number of days consumed of those who received pills. (OR)	MT KPC Final KPC OR	Annually	Kaduha 80.4% received (CI: 72.29-84.51%) Average days: 35.37 Kigeme 81.4% received (CI: 77.38-85.42%) Average days: 33.45		90% 60 days 90% 60 days	ASM training, BCC, household visit, advocacy to improve quality of ANC

IR	Result/ Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measurement Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring Data Sept 11-Oct12	EOP Target	Related Activities
	III. Control of Diarrheal Diseases (15% LOE)							
IR1	**Prevention** Increase % of households that treat water effectively	<u>POU Water Tx:</u> Percentage of households of children age 0-23 months that treat water effectively. (RC15, OR)	MT KPC Final KPC	Y3&4	Kaduha 50.0% (CI: 44.83-55.17%) Kigeme 56.4% (CI: 51.28-61.52%)		65% 65%	
IR2	Improve appropriate hand washing practices	Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing. (RC16, OR)	MT KPC Final KPC	Y3&4	Kaduha 38.6% (CI:33.57-43.63) Kigeme 43.9% (CI: 38.77-49.03)		65% 65%	BCC, Home Visit, Hygiene Club rep in Care Group
IR2	Hand Washing at Appropriate times (tracking only)	Percentage of mothers of children age 0-23 months who wash hands with soap at all four key times	MT KPC Final KPC	Y3&4	Kaduha 2.8% (CI: 1.40-5.20% Kigeme 5.0% (CI: 3.10-7.90%)			BCC, Home Visit, Hygiene Club rep in Care Group
IR2	Latrine/toilet in good	Percentage of households of children age 0-23 months that have a toilet facility in	MT KPC Final KPC	Y3&4	Kaduha 15.0% (CI: 11.31-18.69%)			BCC, Home visit, CHW, use church channel to mobilize for hygiene

	condition (tracking only)	appropriate condition			Kigeme 26.9% (CI: 22.32-31.48%)			
IR2	Safe feces disposal (tracking only)	Percentage of mothers of children 0-23 months who disposed of the youngest child's feces safely the last time a stool passed. (Key Indicator)	MT KPC Final KPC	Y3&4	Kaduha 71.4% (CI: 66.73-76.07%) Kigeme 82.8% (CI: 78.90-86.70%)			BCC, Home visit, CHW, use church channel to mobilize for hygiene
IR1	**Prevalence** Two week prevalence of diarrhea (tracking only)	Percentage of children 0-23 months with diarrhea in the previous two weeks (Key Indicator)	MT KPC Final KPC	Y3&4	Kaduha 17.2% (CI: 13.30-21.10%) Kigeme 19.4% (CI: 15.32-23.48%)			BCC, Home visit, CHW, use church channel to mobilize for hygiene
IR1	Improve home management of diarrhea (ORT use, increased fluids and continued feeding)	Percentage of children age 0-23 months with diarrhea in the last 2 weeks who received ORS and/ or recommended home fluids. (RC13)	MT KPC Final KPC	Y3&4	Kaduha 23.1% (CI: 12.85-33-35%) Kigeme 22.9% (CI: 13.06-32.74%)		70% 70%	CHW refresher training on CCM, BCC, household visit
IR2		Percentage of children 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness. (Key Indicator)	MT KPC Final KPC	Y3&4	Kaduha 36.9% (CI: 25.17-48.63%) Kigeme 40.0% (CI: 28.52-51.48%)		70% 70%	CHW refresher training on CCM, BCC, household visit
IR2		Percentage of children 0-23 months with diarrhea in the	MT KPC Final KPC	Y3&4	Kaduha 63.1%		75%	

		last two weeks who were offered the same amount or more food during the illness. (Key Indicator)			(CI: 51.37-74.83%) Kigeme 64.3% (CI: 53.08-75.52%)		 75%	
IR1	**Zinc Treatment** Increase use of zinc to treat diarrhea	Percentage of children 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements. (Key Indicator)	MT KPC Final KPC CHW monthly rport	Y3&4 monthly	Kaduha 24.6% (CI: 14.13-35.07%) Kigeme 10.0% (CI: 2.97-17.03%)		70% 70%	
		# of under five children with diarrhea treated by CHWs				Kaduha : 1063 Kigeme: 1131		
	Stock out of Zinc	Percentage of CHWs supervised by HC staff and have stock out of Zinc during the supervision day				Kaduha 12% (61/523) Kigeme 9% (46/512)	 	
	Stock out of ORS:	Percentage of CHWs supervised by HC staff and have stock out of ORS during the supervision day				Kaduha 1% (7/523) Kigeme 2% (8/512)	 	

IR	Result/ Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measure-ment Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 11 – Oct 12	EOP Target	Related Activities
	III. Pneumonia Case Management (LOE 10%)							
IR1	**Prevalence** Two week prevalence of suspected pneumonia (tracking only)	Percent of children 0-23 months with cough and rapid and/or difficult breathing during two weeks prior to survey	MT KPC Final KPC	Y3&4	Kaduha 23.9% (CI: 19.49-28.31%) Kigeme 31.4% (CI: 26.61-36.19%)			BCC, Home visit, CHW, use church channel to mobile for hygiene, promote improved stove
IR1	**Care Seeking** Improve appropriate care-seeking for pneumonia	Percent of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last 2 weeks who were taken to an appropriate health provider. (RC14)	MT KPC Final KPC	Y3&4	Kaduha 44.2% (CI: 33.70-54.70%) Kigeme 45.1% (CI: 35.93-54.27%)		70% 70%	BCC, Home visit, CHW, use church channel to mobile for hygiene, promote improved stove
		# of under five children with pneumonia treated by CHWs				Kaduha : 1323 Kigeme: 815		
	Timer presence rate:	Percentage of CHWs supervised by HC staff and have timer functional during the supervision day				Kaduha 100% (523/523) Kigeme 94% (482/512)		
	Stock out of Amoxicillin:	Percentage of CHWs supervised by HC staff and				Kaduha 25% (129/523)		

		have stock out of Amoxicillin on the supervision day				Kigeme 30% (152/512)		

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measurement Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring Data Sept11-Oct12	EOP Target	Related Activities
	III. Immunization – Not an intervention; Rapid CATCH Only							
	Measles vaccination (tracking only)	Percentage of children age 12-23 months who received a measles vaccination.(RC9)	MT KPC Final KPC	Y3&4	Kaduha 87.4% (CI: 81.2-92.10%)			Community mobilization, support HC out reach
					Kigeme 83.4% (CI: 76.49-89.10%)			
	Access to immunization services (tracking only)	Percentage of children aged 12-23 months who received Pentavalent-1 (DTP1 +HepB + Hib) by vaccination card or mother's recall by the time of the survey. (RC10)	MT KPC Final KPC	Y3&4	Kaduha 89.3% (CI: 83.40-93.60%)			
					Kigeme 86.9% (CI: 80.30-91.90%)			
	Health System Performance regarding Immunization services	Percentage of children aged 12-23 months who received Pentavalent-3 (DTP3 with HepB and Hib) according to the	MT KPC Final KPC	Y3&4	Kaduha 84.3% (CI: 77.0-89.7%)			
					Kigeme 84.1% (CI: 77.20-89.70%)			

	(tracking only)	vaccination card or mother's recall by the time of the survey. (RC)						

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measurement Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring data Sept 2011 – Oct 2012	EOP Target	Related Activities
	III. Malaria – Not an official intervention; Rapid CATCH							
IR1	**Prevention** LLIN/ITN use	Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night. (RC17)	MT KPC Final KPC	Y3&4	Kaduha 66.9% (CI: 61.80-71.80%)			Support HC to distribute ITN , BCC,
					Kigeme 66.9% (CI: 61.80-71.80%)			
	Prevalence Two week prevalence of fever (tracking only)	Percent of children 0-23m with fever in the past two weeks.	MT KPC Final KPC		Kaduha: 20.8% (CI: 16.61-24.99%)			
					Kigeme: 23.9% (CI: 19.49-28.31%)			
	Treatment of fever Treatment of Fever	Percentage of children age 0-23		Y3&4	Kaduha 14.0%			CHW refresher

	in Malarious Zones (tracking only) NOTE: Because of Rapid Diagnostic Testing, only children with a positive test should receive a drug. This is not reflected in Rapid Catch Indicator.	months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began. (RC12)	MT KPC Final KPC		(CI: 7.60-24.70%) Kigeme 1.2% (CI: 0.0-6.3%)				training on integrated CCM, BCC, Home visit
		# of under five children with fever treated by CHWs				Kaduha Kigeme	60 22		
	Stock out Primo Jaune:	Percentage of CHWs supervised by HC staff and have stock out of Primo Jaune during the supervision day				Kaduha Kigeme	7% 38/523 26% 133/508		
	Stock out Primo Rouge:	Percentage of CHWs supervised by HC staff and have stock out of Primo Rouge during the supervision day				Kaduha Kigeme	7% 38/523 12% 62/512		
	Stock out of RDT:	Percentage of CHWs supervised by HC staff and have stock out of RDT during the supervision day				Kaduha Kigeme	7% 34/523 13% 67/512		
IR1	Care-seeking for fever	Percentage of children age 0-23 months with a febrile episode during the last two	MT KPC Final KPC CCM monthly report	Y3&4 Monthly	Kaduha 53.30% (CI: 42.01-64.59%) Kigeme 52.3% (CI41.74-62.86%)				CHW refresher training on integrated CCM, BCC, Home visit

	(Measured because of RDT issues explained above.)	weeks who sought treatment from appropriate provider.							
	Referral rate:	Percentage of under five children presenting with danger signs or below 2 months who are referred by the CHWs				Kaduha Kigeme	22% 699/3157 39% 1274/3285		
	Counter Referral rate:	Percentage of counter referral received by CHWs				Kaduha Kigeme	40% 282/699 67% 858/1274		

IR	Result/Objective	Indicators (OR) = OR Indicator (RC) = Rapid CATCH 2008 (Key Indicator) = Recommended by USAID	Source/ Measurement Method	Frequency of data collection	Location and Baseline Value (95% Confidence Int.)	Monitoring Data Sept11-Oct12	EOP Target	Related Activities
VII. Process Indicators related to CHWs and Nutrition Weeks								
IR2	Contact with CHW for health education: Percent of households with children 0-23 months that received health information from a CHW in the past month, according to location (home visit, community meeting,		MT KPC Final KPC	Y3&4				Not Collected at baseline; for future tracking

	health facility, Growth Monitoring and Counseling, Nutrition Week, etc.)						
IR2	CHW Home Visits Percent of households with children 0-23 months that received a visit from a CHW in the past month, according to reported purpose	MT KPC Final KPC	Y3&4	Kaduha 26.7% (CI: 22.13-31.27%) Kigeme 21.9% (CI 17.63-26.17%)		75% 75%	CHWs and Local leaders plan in CG home visits, Care Group visit homes monthly
IR3	Participation in Nutrition Weeks: Percentage of mothers with children 0-23 months who participated in "Nutrition Week" intervention at least once in the past 6 months for 4 or more days.	MT KPC Final KPC	Y3&4 Quarter-ly	Kaduha *Pilot NW sessions in Rusekera Cell*	Lactating mothers 97.75% (87/89) Pregnant women 78.57% (11/14)	80%	Community mobilization, organize NW,
	# of modified CG implemented				Kaduha 282 Kigeme 254		
	Reporting rate: Percentage of CHWs/Binomes that have submitted reports per month				Kaduha 99% 557/564 Kigeme 99% 501/508		
	Reporting rate: Percentage of ASM that have submitted reports per month				Kaduha 99% 278/282 Kigeme 100% 254/254		
	Supervision rate by HC staff: Percentage of CHWs supervised by HC staff (quarterly)				Kaduha 93% 523/564 Kigeme 101% 512/508		
	Supervision rate by CHWs cell coordinators: Percentage of CHWs supervised by CHW cell coordinators (monthly)				Kaduha 93% 523/564 Kigeme 101% 512/508		

Objective/Sub-Objectives	Key Indicators	Data Source and frequency
OR objective: Identify a feasible way to reduce and prevent undernutrition in infants and young children of ages 6 months to 23 months in Nyamagabe District, Rwanda (To assess the effectiveness of Nutrition Weeks in reducing and preventing undernutrition)	• Proportion of infants and young children age 6m-23m fed according to the Minimum Acceptable Diet (WHO 2008) ***(Primary Outcome)*** • Increase in number of food groups consumed in 24 hours for breastfeeding and non-breastfeeding children 6-23 months. • Meal frequency (per day). • Proportion of infants and young children having timely introduction of complementary foods. • Proportion of infants and young children who are actively fed (whether someone assists the child with feeding).	KPC and monitoring surveys, annual
SO 1: Identify key messages to develop the content, key messages and format of the *Nutrition Week* intervention.	Desk Review Completed	Annex to DIP – May 2012
	Market Surveys Conducted	Annex to DIP-May 2012
	Positive Deviance Inquiries conducted	Annex to DIP-May 2012
	Input obtained from Primary Investigator and Co-PI and Co-Investigators, Nutrition Technical Working Group and District stakeholders	Project records – July 2012
SO 2: Train MOH and CHWs/local leaders in how to run Nutrition Weeks	Curriculum and lesson plans developed, including field testing	Project Records
	Number of training sessions implemented	Project Records
	Pre and Post-Tests for CHWs and Social Affairs	Project Records
SO3: Implement Nutrition Weeks 3 times per year	Number of Nutrition Weeks implemented per year	Project Records
SO4: Revise Curriculum	Meetings to solicit feedback on pilot training experience and suggested revisions	Report from feedback meeting, following pilot implementation
	Exit interviews with mothers for feedback on their experience in nutrition weeks	Exit interview report, After pilot test
	Input received from MOH Nutrition Technical Working Group	Meeting notes
	Revised Curriculum	Curriculum
SO5: Scale up to all of Kaduha Zone	Number of sectors with Nutrition Weeks implementation	Project Records

Please refer to the Operations Research Concept Paper for detailed information on the project's formative and summative research and process documentation for the operations research on Nutrition Weeks intervention

Annex 2: Year 2 Workplan of Activities from the DIP

Table 6. Year 2 DIP planned activities, per Quarter (Q).

IR	Key Project Activities	Q 1	Q 2	Q 3	Q 4	Key Personnel
IR2	Quarterly Meetings with Partners	X	X	X	X	ICSP Manager M&E Officers
	Quarterly District JADF Meeting	X	X	X	X	ICSP Manager ICSP Staff
IR2	Quarterly meeting for Care group leaders and supervisors	X	X	X	X	Tangiraneza ICSP CM Officers, In charge of Social affairs at cell level
IR2	Quarterly meeting with Local Leaders and Religious Leaders on BCC.	X	X	X	X	Tangiraneza ICSP CM Officers In charge of Social affairs at cell and sector levels
IR1	Care Group Leaders lead monthly Integrated CGs	X	X	X	X	Care Group Leaders
IR1	BCC (Household health education)	X	X	X	X	Care group Members: CHW, Village Leaders
IR1	Follow up Care Group BCC activities	X	X	X	X	Tangiraneza ICSP CM Officers In charge of Social affairs at cell level, CHW Cell Coordinators
IR2	Distribute annual incentives to CG members				X	Tangiraneza ICSP CM Officers
IR2	Mobilize churches to assist vulnerable households with kitchen gardens & tippy taps.	X	X	X	X	Tangiraneza ICSP CM Officers
IR2	Participate in Nutrition Technical Working Group; Solicit input and share findings.	X	X	X	X	ICSP Manager, HO Tech Unit; ICSP Nutrition Officers
IR3	Train Village Nutrition Committees on Nutrition Week	X	X	X		ICSP Nutrition Officers, MOH
IR2	Participate in DPEM semi-annual meeting.	X		X		ICSP Manager, ICSP Nutrition and Community Mobilization Officers
IR1	Implement and follow up Growth Monitoring sessions	X	X	X	X	CHWs; HC In charge of CH activities
IR1	Implement and follow up Kitchen Garden and assist vulnerable Families	X	X	X		CHWs, In Charge of Social affairs at cell level, Sector Agronomist
IR3	Develop the study protocol to present to RNEC for Year2 OR		X			
IR3	Implement Nutrition Weeks Innovation/ OR activities	X	X	X		Village Nutrition Committee, ICSP Team. In charge of Social Affairs and HC in charge of Nutrition
IR2	OR to compare CBNP, 'Nutrition Week' Innovation, and control communities, prior to district level scale-up			X	X	UBC, MOH, ICSP Officers, HO Technical Unit
IR2	Support HC to supervise ASM providing Newborn and post partum care	X	X	X	X	ICSP MNC Officers, HC; ASM
IR1	Community Case Management Refresher training	X				ICSP CCM Officers, MOH
IR2	Support HC staff to supervise CCM	X	X	X	X	ICSP CCM Officers, HC

	activities					
All	Review/Planning Meetings with MOH	X		X		ICSP Manager, WRR Director of Programs
All	Monthly and Annual Reporting	X	X	X	X	ICSP Manager, M&E Officers
All	Annually Health Resources Tracking Report				X	ICSP M&E Officer
All	Monthly Trainer Report	X	X	X	X	ICSP M&E Officer
All	Monthly Health Information System reporting	X	X	X	X	MOH M&E Managers
All	Community-Health Information (Data Collection and Analysis)	X		X		ICSP M&E Officers, MOH, CHWs,
All	Quarterly Analysis of M+E data and feedback skill-building at HC and District levels	X	X	X	X	M&E Officers; MOH
All	Annual CHW Performance Review			X		ICSP CCM Officers, MOH
All	Project monthly meetings	X	X	X	X	ICSP Manager and Officers
IR3	Annual and Final Evaluations & OR Dissemination				X	UBC, HO Technical Advisor, ICSP Manager

Annex 3: Social Behavior Change Strategy

The BCC model builds on the social change theory used by Care Groups and the Positive-Deviance/Hearth model. It has elements of **Social learning theory (**which contends that people learn within a social context, facilitated through modeling and observational learning) and **Social influence theory,** which states that people's emotions, opinions, or behaviors are affected by others.

The Care Group model developed by Dr. Pieter Ernst as part of the first CSP by WR Mozambique showed that even the most intransigent health behaviors could change relatively quickly (in some cases, within 1-2 years), when the community was saturated with BCC messages shared by a trusted neighbor. Care Group networks of volunteers could visit every home to share messages, with meetings (and new messages) being introduced bimonthly. When entire communities were taught at the same time (everyone living in a home: grannies, mothers-in-law, fathers, mothers, and even older children), then when a family did accept the message and change, they had support within their family and community for that change. Even isolated homes that were reluctant to change bowed to peer pressure (and sometimes a visit from the village chief) and changed their health practices.

The Care Group model has elements of **Social impact theory** (Bibb, Latane, 1981) which states that there are three factors which will increase people's likelihood to respond to social influence: *Strength*: The importance of the influencing group to the individual. *Immediacy*: Physical (and temporal) proximity of the influencing group to the individual at the time of the influence attempt. *Number*: The number of people in the group.

Feeding practices in particular are very socially-dictated. By educating all mothers of children in their first 1,000 days, along with mothers in law and fathers (invited for certain sessions), and also reinforcing behaviors via home visits later by CHWs, the program hopes to effect a sustainable change in feeding norms for entire communities. For example, at present, it is

believed that avocados give children liver disease. So, a perfectly good high-fat food that children would benefit from is not being given, because of an incorrect social norm. Also, porridge is traditionally prepared very thin (even drinkable), because that is how it has always been. Instead, people can learn to make thicker, more nutrient dense porridge.

Changing meal frequency will involve inserting new cues to action in their day. Presently, children are fed when adults eat, which may only be 1-2 times per day. Teaching about the importance of 4-5 meals per day for small children will need to be accompanied with helping families develop new cues for feeding children. (Staff discussed the value of printing up a small poster for households to put up with visual reminders of key practices (Meal frequency, diversity, nutrient density, animal fat/protein, and active feeding)

Positive-Deviance/Hearth methodology for BCC stresses a small group practicing optimal feeding practices together every day for 2 weeks. Due to time and financial constraints, WR is experimenting with having Nutrition Weeks three times in a calendar year, with CHWs supporting the new behaviors with home visits in the weeks following the intensive time of practice with the new behaviors (the Nutrition Weeks themselves).

This model uses geographical saturation of the messages, plus hands-on practice of the new behaviors, and facilitating adoption of new social norms for feeding practices of infants, children under two and pregnant women.

Annex 4: 2012 update on progress of the Operations Research (OR) study

Progress made in key tasks/activities, achievements, challenges, and any learning generated from implementing the innovation intervention/s in the past year.

The Nutrition Weeks pilot has progressed steadily in the first year, reaching all key benchmarks; WRR staff obtained approval to conduct the study from the Rwanda Ethics Committee, two members of the Rwandan National MOH staff are Co-Investigators for the Operations Research, and after baseline assessments, the Nutrition Weeks curriculum was developed, testing and piloted beginning in September of 2012.

The innovation (intervention/strategy) being tested, the program barrier/s it is meant to address, key approaches used, and expected results.
The innovation being tested is an intervention called "Nutrition Week." Melene Kabadege, who has worked with WRR health programs since 2000, conceived of a program that could be carried on by MOH staff and existing volunteers, that would sustainably change feeding behaviors in a low-cost and replicable manner. Nutrition Weeks are a hands-on intensive behavior change strategy aimed at improving feeding practices of mothers of children in their first 1,000 days of life. Nutrition Weeks will be held three times per year in addition to the standard MOH Community-based Nutrition program (CBNP) in the intervention area. CHWs will receive training and a step-by-step guide to implement a Nutrition Week.

Key approaches of the Nutrition Week are: 1) to include all pregnant women and women with children under two women, which will facilitate peer learning and changed community norms. 2) They will spend two hours a day for five days in small groups of up to ten, led by their CHW who is trained by MOH staff, who in turn were trained by WRR CSP staff. 3) Nutrition Week sessions are patterned after PD-Hearth, each day mothers will learn about, practice and discuss a key behavior that will help prevent their children from becoming undernourished. 4) Nutrition Weeks engage mothers in active learning, and will also train CHWs to more effectively promote behavior change.

Nutrition Weeks are a hybrid of the Positive-Deviance Hearth (PD/H) model for community-based rehabilitation of malnourished children and the 100% coverage and saturation-teaching method of the Care Group model. An important difference is that where PD/H focused on undernourished children, Nutrition Weeks will bring together all mothers in a village that are pregnant and/or have children under two years old. While the entire MOH Community-Based Nutrition Program curriculum will be taught, the key IYCF practices that will be emphasized will be discovered from focus groups and PD Inquiries during formative research. The difference between the CBNP program and Nutrition Weeks lies in the hands-on practice with real foods (as opposed to listening to a flip-chart lecture or watching a demonstration), the interaction and communication among mothers (not only from the teacher to the mothers), and a realistic acknowledgement and discussion of the barriers most mothers face in adopting recommended IYCF practices.

Program barriers the model is meant to address.
Rwanda has developed numerous national policies and strategies to integrate food security and nutrition with poverty alleviation, ie: the National Strategy to Eliminate Malnutrition (NSEM, 2010), Vision 2020, the Poverty Reduction Strategy Paper, the National Policy on Health, and the National Policy on Agriculture, all of which have a focus on the promotion of better nutrition for the population and introduce steps intended to improve nutrition, particularly for young children. Yet, as stated in the NSEM, "*The nutritional situation in Rwanda remains persistently poor. For the last two decades, undernutrition remains a significant public health problem contributing to the high infant, child and maternal mortality*." Factors specific to Rwanda that contribute to the high levels of undernutrition include that it has one of the highest population densities in Africa, despite recent FP programs which have lowered the fertility rate. [1](2010 DHS)"

Nyamagabe district also suffers from poor soil quality, high poverty levels, and suboptimal feeding practices such as giving children a thin, watery porridge, low food diversity, low consumption of animal-source protein, and an inadequate number of meals per day. Rwandans also have one of the lowest fat intakes in the world (9%).

Given the high prevalence of undernutrition in Rwanda[2] and the lack of quantitative data on the effectiveness of the CBNP, this operational research study aims to identify the most feasible way to reduce and prevent undernutrition in the first 1000 days of life of children in Nyamagabe District, Rwanda through formative research, and then to test Nutrition Weeks to evaluate if the intervention is more effective than the standard CBNP.

Expected results of the Innovation: improved feeding practices for pregnant women and children under 2 years of age. This operations research (OR) study will provide data not only from the intervention area but also from the comparison area where the standard CBNP will be implemented, thereby yielding data on the standard CBNP. If the OR findings indicate that the incorporation of the Nutrition Weeks intervention into CBNP is more effective than the standard CBNP, the data will inform the MoH's decision-making process and will contribute to the international body of knowledge on feasible approaches to preventing undernutrition.

[11] "Currently, women in Rwanda have an average of 4.6 children, down from 6.1 in 2005. Nyamagabe district's total fertility rate is 5.1

[2] Measure DHS, Rwanda 2010

Progress on Key OR study milestones

Table 7. OR Study Progress and Achievements in Year 1

OR Study Key Milestones	Related Key activities as outlined in OR Concept paper	Progress/ status of OR activities	Comments (challenges, contributing factors, change, etc.)
Ethical approval	Presentations to the MOH (in Jan.) and the Rwandan Ethics Committee (in Feb.)	Completed	A new policy required MOH approval before WR could present to the Ethics Committee, which delayed the approval of the OR (and thus the KPC) by one month.
Completion of formative research phase	KPC baseline survey, Focus Groups, literature review,	Completed	
Development of Nutrition Weeks curriculum (three levels: training mothers, training CHWs, and training MOH TOT.)	Development of draft NW curriculum. Review by Judy Mclean and Judiann McNulty Development of "behavioral cues poster" for distribution to homes Pre-testing curriculum	Completed	Please see annex 9 for Nutrition Weeks Curriculum and Poster.

Documentation of Key OR activities

Time commitment to prepare the Rwanda Ethics Committee Study Protocol: Preparation of the Study Protocol (and the OR Concept paper for USAID) was significant. All WR HO technical team members spent at minimum 40+ hours on the study protocol, revisions to the study protocol, and Field staff spent 40+ hours in meetings with MOH staff and writing the necessary reports for the various meetings. It was not easy to get meetings with upper-level MOH staff, and obtaining meetings and conducting these meetings took many hours of WRR staff time. WRR staff presented the Nutrition weeks OR to Dr Fidele Ngabo (and Alphonsine Nyrahabineza), the Director of the MOH Maternal and Child Health Unit on May 10, 2012.

WRR staff met with the Rwandan MOH Nutrition Working Group to get their feedback on May11, 2012.) Their recommendations and WR responses are summarized in the table below.

Table 8. Nutrition Technical Working Group recommendations on Nutrition Weeks

Nutrition Technical Working Group recommendation	WR Response, change to Operations Research / Nutrition Week implementation
Two weeks a year is not enough; perhaps 3 or quarterly would be more effective. (At first they wanted quarterly, but we compromised on three times per year.)	This was changed to three times per year in response to feedback. WR is concerned that with 4 weeks a year MOH would not be able to scale it up effectively.
How will the Comparison group not get contaminated?	There is no way to control for contamination if relatives visit each other on either side of border between the two hospital zones; WR acknowledges that contamination, especially for

Their main concern was that we need to look into the programs that are already taking place in the two areas and make sure that there are not other organizations doing a similar interventions (ie. livelihood programs) They suggested that these factors be taken into consideration when we do our Desk Review.	communities near the border, may occur. We mentioned that we are going to control for socio-demographic factors between the two groups. We must research which other NGOs are working in the two areas and we must also obtain any available anthropometric data on the population. This will allow us to control for extraneous variables that can affect the results of our OR study.
Is the National Maternal Health & Nutrition Week combined with the WR proposed Nutrition Week?	WR agrees it is too much to supervise both simultaneously; Nutrition Weeks will be held at a separate time.
Concerned that the two areas being compared are different, one is urban and one more rural.	WR collected socio-demographic data on both of these areas; while some differences exist, they are more similar than different. It was intentional to select the more remote zone (Kaduha) for intervention, least improvements be ascribed to factors inherently in favor of the intervention population.
Suggested a stakeholders meeting with all partners involved with interventions in the same areas.	WR is aware of other organizations in the district – and will document any other nutrition interventions being implemented by other organizations in overlapping geographic areas.
The Nutrition Weeks training curriculum must work in collaboration with the MOH to avoid any duplication.	Yes, the Nutrition Weeks curriculum will be developed with MOH input and approval. However, WR will need to lead development of a draft curriculum for MOH review so as not to delay implementation. As the curriculum will emphasize selected messages already in the approved MOH IYCF curriculum, the content should not be controversial. The NW model differs primarily in it methodology (more hands-on like Hearth) than in its messaging.
Collaborate with local leaders.	Yes, in fact several local leaders per village will be chosen to be trained as a Care Group volunteer.
WR should use existing data for baseline.	There was not baseline data specific to the population, indicators and timing of the start of the project/OR, so it was collected in conjunction with the baseline KPC survey.
Working in close collaboration with MOH/NTWG and with local leaders	We agreed that this is important and that we have already included it in our plans. This will avoid misuse of funds and duplication of efforts. The CSP is working closely with local leaders.

In February, WRR staff officially presented the Study Protocol to the Rwanda Ethics Committee That paper is 103 pages long and is not included as an annex to this report because it would be confusing. WR already has the OR Concept paper that includes all that information. We can report that it was several days, possibly weeks of staff time devoted to writing it, setting up meetings with the Rwanda Ethics Committee, and actually presenting the Study Protocol. They approved the study with no modifications.

WRR staff decided on the sample size for the KPC to achieve sufficient statistical power, and revised the KPC to collect the information required by the study. This necessitated doing a double KPC (one in intervention area and one in the control area.)

Results of Desk review of relevant international guidelines, (WHO standards for IYCF, *Essential Nutrition Actions* and the *Community Based Nutrition Protocol* used in Rwanda.) Also, results of

the review of existing documentation of local practices, (such as the 2010 DHS, the MNP Project, the *Unicef Sprinkles Phase 1 report*, other nutrition studies done in Rwanda, the project KPC, and other findings on extant practices.)

Results of the Market survey tool is in the DIP.

Results of Positive-Deviance Inquiries using semi-structured interviews and observations was also a DIP annex, and the information used in developing the NW Curriculum

How all the above formative research contributed to developing the content, key messages, and format of the Nutrition Week intervention. All of the above formative research contributed to developing NW content, messages and curriculum. There were multiple meetings, workshops, and drafts of the curriculum developed in the field, and input from Judy Maclean, Judiann McNulty, the WR HO Technical Unit and input also from the Rwandan Nutrition Technical Working Group (see table above outlining their recommendations.)

How the Nutrition Week materials were developed and pilot-tested (Complete curriculum content and lesson plans for the Nutrition Week intervention can be found in Annex 9.)

Complete curriculum content and lesson plans for the Nutrition Week intervention
Along with the formative research done, NW curriculum was revised based on user feedback from trainers and caregivers. Master trainers offered feedback on the curriculum suggesting food quantity based on age should be added to NW curriculum alongside food frequency.

Feedback from maternal and CHW exit interviews, and how these were used to improve future sessions.
Maternal exit interviews displayed a considerable amount of appreciation for the new behaviors learned, even asking to extend nutrition week to 7 days in the future. The mothers also independently proposed to meet once a week in order to review the lessons of NW further highlighting the impact NW has on mother. The considerable positive response advocates for the scaling up of this approach to reach more mothers in the district.

Results of CHW written pre- and post-tests related to the content and execution of the Nutrition Weeks curriculum before and after their training, and how these were used to improve future sessions.
The results of the CHW post-tests from the first Nutrition Week in September (97% correct responses) prove the effectiveness of NW training curriculum. Staff made minor changes to the curriculum to address CHW needs and to reinforce the importance BCC.

Annex 5: Papers or Presentations about Project

The Project has just begun, so there has not been much opportunity for presentations or publishing data. Melanie Morrow, of the WR HO Technical Unit presented the baseline KPC results to the MOH MCH Technical Working Group. In September, Melene Kabadege presented the CSP to the Future Generations Alumni Symposium in Kenya, and WR has begun making plans to present the project and preliminary results at the CORE Spring meeting.

Annex 6: Results Highlight

The project has just begun, and is implementing an innovative idea already. As data on the project innovation becomes available, WR will document both implementation and results of the innovation.

Annex 7: MOU between World Relief & Judy Mclean of University of British Columbia

Consultancy Agreement

August, 2012

Between Dr. Judy McLean of the University of British Columbia and

World Relief, Baltimore

For support of World Relief Rwanda's Innovation CSP in Nyamagabe District

USAID Child Survival and Health Grants Program

Dates of operation: October 2011-September 2015

Contacts List

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Parties involved and their overall roles and responsibilities:

Names	Affiliation	Responsibilities
Dr. Judy McLean	University of British Columbia (UBC)	Principal Investigator; Responsible for developing the research design; Providing technical oversight to tool development and methodology for KPC baseline & OR; Oversight of quality data collection and analysis; Facilitate the development of an agreement between the International Nutrition Group in the Faculty of Land and Food Systems at UBC and World Relief; Provide International Nutrition students for field support; Disseminate the results beyond Rwanda.
Melene Kabadege	World Relief Rwanda	Co-Investigator of Operations Research; provide technical assistance for tool and protocol development; Lead the KPC survey implementation; Overall coordination of data collection at field level, data analysis and reporting writing.
Dr. Fidele Ngabo, MCH Director	MOH National level	Dr. Fidele Ngabo is the Co-PI in Rwanda MOH As MOH staff in Rwanda, facilitate working with Ethics Committee, liaise with other MOH staff and Directors to present study and program findings. Disseminate results to other MOH and Ministries of government in Rwanda and help with scale-up, as determined by the government of Rwanda.
Alphonsine Nyirahabineza	MOH Nutrition specialist	Co-Investigator in Rwanda Provide input to research; follow the results to ensure that the findings are relevant; facilitate the finding dissemination throughout Nutrition Technical Working Group.
District Health Team represented by the Director of Health or Medical Director	MOH District Level	Implementing partner; Oversee the implementation of the survey in their respective district; Provide surveyors and supervisors; Assist with community mobilization.
Melanie Morrow	World Relief – Home Office	Review protocol & tool development and report; Submit KPC report to USAID.

Molly Newman	University of British Columbia	Provide technical assistance for survey training, data collection as well as data system setup, and English report-writing for KPC and formative research studies. See table of responsibilities below.
MOH/Nutrition Desk representative	MOH	MOH Nutrition specialist**;** provide input to research; follow the results to ensure that the findings are relevant; facilitate dissemination of findings throughout Nutrition Technical Working Group.
Olga Wollinka	World Relief – Home Office	Provide technical assistance for tool, protocol development and reporting; writing; Develop MOU with UBC.
Carmen Grace Umutoni	World Relief - Rwanda	Contribute to protocol development, data analysis, and report writing; Liaison with the district and MOH central level; Lead questionnaire and consent form translation process into Kinyarwanda; Responsible for budgeting, logistics; Community mobilization.

Key Deliverables by UBC Faculty and Students

This table is applicable to UBC, while the roles of WR staff were described in the table above. This table may be updated as needed, to be signed again if significant changes are made.

Key Activities	UBC faculty or student involved	Outputs	Deadline
Baseline research in Year 1 Developing research design, indicators, tools, methodology for KPC, formative research and OR design.	Dr. Judy McLean Molly Newman Kristina Michaux	Final review of *OR Concept Paper for the DIP* KPC baseline survey analysis and report writing	May 18, 2012 Detailed Implementation Plan due to USAID
IRB Presentation on February 11, 2012	Dr. Judy McLean and Molly Newman	Dr. McLean to prepare Molly Newman and Melene Kabadege for IRB Presentation, review	February 6, 2012

		and approve PP presentation that WR staff developed.	
Oversight of quality data collection that will be done by WRR team (led by Melene and Melanie), data management and analysis; advising WR HO staff and Melene K. of WRR.	Dr. Judy McLean Molly Newman Other UBC students and staff as needed through the life of the project.	KPC baseline survey report writing	April-May, 2012 April 2013 April 2014 2015 dates TBA
Analysis of OR data for Nutrition Weeks: both quantitative and qualitative (CHW interviews, maternal exit interviews, perceptions of intervention Objective 4 in evaluative research) to provide direction on Nutrition Weeks design and impact measurement.	Dr. Judy McLean Molly Newman Kristina Michaux (plus other UBC International Nutrition students and staff)	Annual report on formative OR data to inform Nutrition Weeks methodology.	May 18, 2012 April 30 2013 April 30 2014 2015 dates TBA
Sign a consultancy agreement between WR Home office and Dr. Judy McLean of the University of British Columbia	Dr. Judy McLean, UBC	Signed Consultancy Agreement	August 2012
Disseminate the results beyond Rwanda.	Dr. Judy McLean Along with any others who "contributed to study design, methodology, data analysis and	Publish findings in relevant scientific journals eg an abstract prepared for the ICN, deadline in February. Presentations at relevant	To be determined

	interpretation." (This could be Melene, Melanie, Olga, possibly other Rwandan MOH or USAID stakeholders.)	conferences	
Annual Reports	Dr. Judy McLean	Write the relevant Operations Research sections of Annual Reports, the Midterm and the Final Evaluation report.	September 2012, September 2013 (Midterm) September 2014 September 2015 (Final Evaluation)
Monitoring visits	Dr. Judy McLean	Monitoring report to WR Home Office	September 2012 Other dates TBA

Compensation Details

Dr. McLean, as a Canadian researcher, is already paid a salary by the Canadian government and therefore does not require compensation for her work on this grant.

Dr. McLean to Subcontract to UBC students as needed

As the administrator of the grant for students, it is most expedient to pay Dr. McLean a flat fee of $10,000 for year #2, $12,500 for year #3, and $12,500 for year #4 for research student assistants who will be involved in documenting and assisting with analysis of data and other tasks as assigned including their international travel as well as that of Dr. McLean, who is responsible for supervision and review of their work for quality assurance. The funds for the first year will be processed immediately after the signing of this agreement, and the funds for each consecutive year will be provided at the beginning of each period. Funds will be processed after receiving an invoice from the consultant providing a general description of expenses for the period in question.

WRR will pay directly for local travel, food and by providing lodging for UBC students or faculty who come to Rwanda while they are working on the Nyamagabe District project from USAID OR grant funds (including IRB Presentation expenses). WRR rented a larger house to be able to provide lodging for staff and guests of the project.

Expenses related to other projects in Rwanda, ie: UNICEF MNP, will be covered by those projects.

Term of Agreement

This agreement starts as of the signing date in August 2012, and concludes after the final work is completed for dissemination of OR results (which could be after the end of the grant.)

Signatures

_____ _____

Dr. Gwen Chapman, Assistant Dean *Date*

Department of Food, Nutrition and Health

University of British Columbia, Vancouver

_____ _____

Gil H. Odendaal, Ph.D, Vice President of Integral Mission *Date*

World Relief

7 East Baltimore Street

Baltimore, MD 21202

Phone: 443-248-7877

Annex 8: Letter of Support from MOH

REPUBLIC OF RWANDA

MINISTRY OF HEALTH

MCH

MATERNAL AND CHILD HEALTH DEPARTMENT

Kigali, on 23 / 02 /2012
N°20/029/1.2 MCH/2012

To the Chair of the Rwanda National Ethics Committee (RNEC)
KIGALI

Dear Chair of the Rwanda National Ethics Committee,

Re: Protocol on data collection for assessments and operations research related to the MOH/World Relief Rwanda Innovation Child Survival Project.

Reference made to the presentation of the protocol entitled: Data Collection for Assessments and Operations research related the MOH/World Relief Rwanda Innovation Child Survival Project Nyamagabe District, Rwanda in the Nutrition Technical Working Group and it approval, I would like to inform you that the Ministry of Health/ Maternal and Child Health Unit approves the protocol and recommend to be presented in the Rwanda National Ethics Committee.

Sincerely,

MINISTRY OF HEALTH MATERNAL AND CHILD HEALTH UNIT

Dr. Fidele NGABO
MCH Director

CC
- Country Director /World Relief Rwanda
KIGALI

BP 84 Kigali Téléphone/Fax 00250 584144 www.moh.gov.rw

Facilitator's Guide for Nutrition Weeks

To be used by Community Health Workers

Introduction

This is a manual for Community Health Workers (CHWs) to use while implementing the Nutrition Weeks Intervention. In the following pages, you will find the schedule for each day of the Nutrition Week, as well as tips for how to run each day effectively.

So what is a Nutrition Week? A Nutrition Week is one week (5 days), held 3 times each year, meant to help mothers change feeding habits to result in well-nourished children. This means changing how they eat when they are pregnant, how they nurse their babies, and how they feed their children up through age 2 and beyond Although we are focused on pregnant women, lactating mothers and children up to 2 years of age for this program, when mothers stop breastfeeding it is very important that they continue giving energy and nutrient-rich foods to their children as this is a time when children feed themselves but their nutritional needs are still high. Instead of teaching, like you do with your regular home visits, this is a time where a group of mothers from the village come together to learn by *doing* —and leave empowered to improve their feeding practices when they go home.

Nutrition Weeks are meant to be very interactive and participatory between CHWs and the mothers involved. They are intentionally with smaller groups (maximum 10 mothers) so that you can have good interactions with all of the participants. Included every day is a chance for small groups to discuss their practices, for women to learn from each other, and learn how to make these changes in a feasible way in their homes.

There are 7 key practices/principles that you will be helping mothers to practice doing all week: 1)making thicker porridge, 2)feeding their children fat and animal-source foods (including exclusive breastfeeding up to 6 months and continued breastfeeding until 2 years of age) 3)increasing frequency of meals (starting with 2 meals at 6 months, increasing to 3 meals and 2 snacks each day), 4)eating a variety of foods, 5)improving hygiene practices,6) infant stimulation and active feeding, and 6)health of pregnant women. You will practice each of these every single day through cooking practices and discussions. Drawing on what you learned from the Behavior Change module of your training for Nutrition Weeks, you are there to help women believe they can actually make these changes in their homes! For the weeks afterwards, you will be responsible for visiting the mothers in their homes to see if they have adopted the new practices, to encourage them and to answer their questions. As you lead the Nutrition Week and do these home visits, you will hopefully see mothers start to adopt these practices, meaning that the mothers and children in your village will become healthier and grow up strong!

Table of Contents

Acronyms

BCC	Behavior Change Communication
CHWs	Community Health Workers
ICSP	Innovation Child Survival Project
MCH	Maternal and Child Health
MIYCN	Maternal and Infant Young Child Nutrition
MNC	Maternal and Newborn Care
MOH	Ministry of Health
NW	Nutrition Week
WR	World Relief

DAY 1: MAIN TOPIC: EATING THICKER PORRIDGE

Training Objectives

At the end of this topic, the participants will be able **:**

- To prepare and to feed thicker porridge to their children starting at six months of age
- To mix flours for thicker porridge
- To feed more frequent meals and snacks (at 6 months start 2 meals and 1- 2 snacks in addition to continued breastfeeding. Then from 6-9 months gradually increase to 2-3 meals and 1-2 snacks. From 9-24 months: 3-4 meals and 1-2 snacks. It is important to stress the importance of continued breastfeeding because this is the child's main source of energy and nutrients. Also, to have a separate cup for the child's food.
- To wash regularly their hands at the four recommended key times
- To take an extra rest and an extra meal for pregnant mothers

Methods

- Asking questions (both direct and brainstorming questions)
- Small Group discussions or discussions while cooking and feeding
- Group work (Cooking practiced by mothers, mothers–in-law, infant stimulation, hygiene…)

Materials and Tools

Cooking supplies and materials

- Wood for fire (and matches)
- 2 Pans (for making porridge)
- Jerry cans to transport water
- Soap, sponges, and tubs for washing dishes
- Big Spoon (for cooking
- Palm Oil
- Flour for porridge (can be sorghum, maize or wheat flour, depending on the area.)
- Cups
- Snacks for small children (small bananas) (There will be an announcement during the community mobilization meeting on what should be brought for the first day of the NW)

Counseling Cards for MIYCN

DAY 1: MAIN TOPIC: EATING THICKER PORRIDGE

Introduction

✓ Opening & Welcome mothers and mothers in law ***(5 minutes)***

✓ check children for sickness and refer to the HC if is sick

✓ Introduce Nutrition Week and Topic for the Day (making and feeding thicker porridge to kids over 6 months of age) *(10 minutes)*

Nutrition Week

- ✓ Nutrition Week is a time where you can come and learn how to better feed yourselves and your children, which will help to make them healthy, strong, and smarter)
- ✓ Children's stomachs are only the size of their fist, and so they need to eat more often! Adult's stomachs are bigger, so we can eat less frequently.
- ✓ check children for sickness and refer to the HC if is sick

Topic for the day: Thickness of porridge.

- ✓ Porridge is good for babies to eat (not to drink!), but it needs to be thick for them to get all the nutrition that they need. Thin porridge is mostly water which fills the child up for only a short time and doesn't provide nutrition.
- ✓ Eating thicker porridge will help them to fill their stomachs longer, and to sleep better and longer
- ✓ Also good to bring up here the use of a child's bowl- to wash and use separately to keep track of how much is fed to the child.
- ✓ The point of this week is to involve the mothers as much as possible. Have them help make the porridge.

Step 1: Practice Cooking and child feeding (1 hour)

- Collect materials that women brought for first day ***(5 minutes***
- Collect the flour

a. <u>How to mix the flour for thicker porridge</u>

- ✓ ***ASK****: what is thicker porridge?*
- ✓ ***LISTEN*** *their answers and show them pictures of the thicker porridge*
- ✓ ***ASK****: have you ever make and fed your child thicker porridge? If yes give us the testimonies and discuss on that.*
- ✓ ***ASK****: What is the importance of thicker porridge for child?*
    - Porridge is good for babies to eat (not to drink!), but it needs to be thick for them to get all the nutrition that they need.
    - Eating thicker porridge will help them to fill their stomachs, and to sleep better and longer
- ✓ ***ASK*** *: what kind of flours do you use to make the porridge in this area and how to mix the flours ?*
- ✓ ***TELL*** *them how to mix the flour for ten children take ten spoons for sorghum flour ,ten spoon for maize flour and four spoons of soy flour. (We will discuss how mothers can get different flour types (trading with other mothers, etc.) and that it is the thickness that is important, even more than combining the types.*

b. <u>Cooking direction but they must remember to practice good hygiene</u>

- ✓ ***ASK*** *: How to cook thicker porridge? Put the mothers in small group to discuss how to cook ticker porridge*
- ✓ *After the small group work , ask the participant to make a summary as following :*
    - Put the water in good recipients on the fire till boiled
    - Mix the flours in bowl

- Mix that mixture of flours with the cold water
- Put that thicker mixture into the boiled water
- Mix till the 1st boiled and add 2 spoons of palm oil
- Continue to mix till well boiled
- Make cool to the child with small spoon

Note for session leaders: the session would go much faster if the first ones to arrive go fetch water and start the fire, instead of waiting until now. Maybe, at this point, some will need to go get more water for hand-washing , but most of the cooking water should be already on the fire to boil. Mothers have so much to do, we must be as efficient as possible with the NW session so as not to keep them from their work at home too long.

- ✓ *Split the group of mothers into three sub groups:*

- one group responsible for looking after kids,
- one group for getting water to cook,
- one group responsible for starting the fire to cook, ask the mothers in-law to cook

- ✓ *Wash Hands for children*
- ✓ *As they go to wash their hands, this is an opportunity to* ***TALK about the 4 times that you need to wash your hands:*** *before cooking, before feeding the baby, after attending a child, after using the toilet.*
- ✓ ***ASK*** *the mothers when they need to do this, use this time as a learning and discussion opportunity as they are washing their hands*

- After Cooking thick porridge, divide it into the children's cups and cool it. (While the porridge is cooling, we can teach mothers and caregivers infant/early childhood stimulation activities.)
- Serve the porridge to the children with small spoons and cups

- Feed the children
- Show them how to feed their child and have them practice
    - Feed younger children, and practice how to help older children feed themselves.
    - Use a separate plate to feed each child to make sure he or she eats all the food given.
    - Children need more frequent feedings (2 meals at 6 months, increasing to 3 meals by 9 months, and 3-4 meals 9 months- 2 years. Snacks are 1-2 times per day. And, most importantly, **breastfeeding should still continue**, as it is a very important source of calories, nutrients and fats for children up to 2 years of age and helps reduce stunting. We will need to keep stressing this.

Step 2: Hygiene Practice. Split up the mothers into smaller groups

- One group Clean up the children-hand washing, etc.

- Other group Cleaning Dishes (use of dish racks to keep clean. The volunteer should explain why we use the dish racks and how to make one. Mothers can brainstorm about where to get the materials.)

Step 3: Discussion on Key feeding behaviors (thicker porridge)

- Use a participatory style (no lectures) to talk about the topic focus, thicker porridge.

- Ask "why porridge is made this way in Rwanda?" This will bring up the reasons, which then they will realize are not good reasons at all, it is just habit. People tend to eat the way they have grown up eating.) It is true that when a 6 month old baby is first learning how to eat, porridge needs to be soft (they can choke on porridge that is too thick.) So, in the first weeks of giving porridge it can be soft (not liquid), but gradually it can be made thicker, so that by 7 months they should be able to eat thicker porridge without choking.

- Answer questions that mothers have about this, talk about problems that mothers have to making porridge thicker, and so on.

- Help these mothers realize that it is possible for them to do this at home! Ask them how many are willing to try to make thicker porridge later today or early tomorrow for their child.

- Discuss how the mothers-in-law can be involved in making porridge thicker—making sure that they are doing so when they are taking care of the children.

- Discuss that women need extra rest and an extra meal daily when pregnant in order to deliver a healthy baby

Step 4: Review and Discuss the Lesson for the Day (15 minutes)

- Ask questions about how to make the thicker porridge
- Why is thicker porridge important?
- How thick should the porridge be?
- Why do we need to increase the number of meals children eat each day?
- What do you need to do before you begin to cook and eat?
- What are two key behaviors pregnant women should have in order to deliver healthy children?

Step 5: Prepare for the next day

- Decide who is bringing what foods, materials
- Nutrition Week song and closure

DAY 2: MAIN TOPIC: EATING FAT AND ANIMAL SOURCE FOODS

Training Objectives

At the end of this topic, the participants will be able :

To feed the child animal source food and fats frequently

To take an extra rest and an extra meal for pregnant mother.

To prepare and to feed thicker porridge to their children which starting at six months of age

To feed more frequent meals (four-five each day, as well as breastfeeding still), and to have a separate cup for eating.

To wash regularly their hands at the four recommended key times

Methods

Brainstorming

Story

Group work or Practice for ex : cooking, hygiene

Materials and Tools

1. **Cooking supplies:**

Wood for fire and matches	Beans
2 Pans for making porridge and food	Onions
Jerry cans for pick water	Green pepper
Flour for porridge	Avocado
Oil	Irish potatoes
Small fish	Snacks for small children
Tubs for hand washing and vegetables	Avocado
Tomatoes	Amaranths

2. **Counseling card for MIYCN**

Introduction *(20 minutes)*

- Opening and Welcome mothers and mothers- in-law
- Checking for attendance

- check children for sickness (refer to HC if they are sick)

- Review for Nutrition Week topic of yesterday and introduce the topic for the Day (Eating fat and animal sauce food for Children and pregnant Mothers)

Nutrition Week

- ✓ Nutrition Week is a time where you can come and learn good feeding habits for you and your children, which will help to make your family healthy and strong)
- ✓ Children's need to eat animal source food for to build a body and get iron to prevent anemia and other minerals and vitamins grow tall and to repair body from illness. Fat is also important for a child's growth. Mothers also need to eat more fat and animal source foods to stay healthy during and after pregnancy and to have a strong, healthy baby.

Topic for Yesterday: Thickness of porridge.

Review on how to make thicker porridge

ASK: *How to mix the flour for thicker porridge?*

ASK: *What is the importance of thicker porridge for child?*

Porridge is good for babies to eat (not to drink!), but it needs to be thick for them to get all the nutrition that they need

Eating thicker porridge will help them to fill their stomachs, and to sleep better and longer

The point of this week is to involve the mothers as much as possible. Have them help make the porridge.

Topic for the day: Eating fat and animal source food

- ✓ Child must eat animal source foods to build a body and to prevent anemia by getting to prevent anemia and other vitamins and minerals grow tall and to repair body from illness.
- ✓ Children need foods that contain fat also for growth and energy.

- ✓ Mothers need to eat more fat and animal source food to build a body and to prevent anemia, to stay healthy during and after pregnancy, and to deliver a healthy baby.

Step 1: Practice with cooking fat-source and animal-source foods (1 hour)

- Collect materials and recipe that women brought for second day

TELL A STORY

One day mama KAGEYO was gone to find the knife at neighbor she has seen mama MURENZI feed his child of 8 months of age the foods which contain avocado and egg, and he asked mama MURENZI, what are you doing ,don't you know that Avocado contain fats that is harmful for child can cause live diseases and also eggs are for sale .Me, I never make that mistake, in that case Mama Murenzi responded Mama MUTESI, that avocado is very well for a child because it contains fats which is good for a child ,fats is energy source ,heats and help child to grow well without malnutrition and egg is not just to sell, and also help a child to prevent anemia, and eggs are also excellent animal protein for growing and to prevent illness and blindness. The child is never sick and is bigger than other children his age, you can give your child one egg, can you see isn' t a problem. Mama KAGEYO said that she is going to do that, I will tell you the results; Mama KAGEYO was going and adopted a good change, her child is rarely sick and is bigger than other children his age.

DISCUSSIONS ON THE STORY

A SK: What is the importance of fats for child? What fat source foods are available in our community?

ASK: What is the importance of animal source foods for a child? What animal-source foods are available in our community? Who has chickens or ducks for eggs? Do you raise goats or cows? How often do you buy(get) goat or beef meat? (***Note that milk is not a good source of iron on zinc***.)

ASK: Can children more than 6 months of age eat animal's sources foods or fat? Why? Why not?

ASK: Can children less than 6 months can eat fat or animal source food? Why? Why not?

TELL them: ***Mother's milk is the best animal-source food for babies under 6 months, and it is still very important for the first 2 years of life. God has given mothers everywhere the best food for their babies- and it is free!***

ASK: Who is going to do that at home?

Step 2: Hygiene Practice

- Clean up the children-hand washing,
- Cleaning Dishes (use of dish racks to keep clean)

- **Getting ready to feed children—** split the group of mothers into three sub groups:
  - one group responsible for looking after kids,
  - one group responsible for starting the fire to cook for child
  - One group responsible for starting to cook for pregnancy mothers .
- **Wash Hands**
  - As they go to wash their hands, this is an opportunity to talk about the 4 times that you need to wash your hands: before cooking, before feeding the baby, after attending a child, after using the toilet.
  - Ask the mothers when they need to do this, use this time as a learning and discussion opportunity as they are washing their hands
- **Small snacks for children** :Avocado
- **Time for cooking thicker porridge and meal**
- **Cooking the daily recipe (whatever food is brought will create the day's recipe)**

Having the mothers participate as much as possible (peeling and chopping vegetables, tending the pot)

The point of this day is to involve the pregnant women as much as possible. To help them to understand and practice every day .in order to become the habit

Ingredients *(the amounts will depend on number of servings, make sure ingredients include Fat and animal source food)*

Tomatoes	Onions
Amaranths	Soy flour
Small Fish	Salt
Oil	Green Pepper
Banana plant	Avocado

Directions for cooking

- ✓ Clean vegetables and remove skins from the banana plant, soak small fish in cold water for 5 minutes
- ✓ Boil pot of water
- ✓ Add banana plant, boil for 15 min.
- ✓ Reduce Heat and Add all vegetables, small fish and oil, stirring and cooking for 15 minutes
- ✓ Add a small amount of salt after vegetables have been cooking for five minutes.
- ✓ After vegetables have been cooking for 15 minutes (30 minutes total including the banana plant), take off heat for serving
- ✓ Mash up cooked food, and then serve to child on a clean plate, with a clean spoon—with one part of avocado.

- **Small snacks for children**—avocado

Show them how to feed their child and have them practice

Active feeding:

- ✓ Help your older child eat.
- ✓ Use a separate plate to feed the baby to make sure he or she eats all the food given
- ✓ Children need more frequent meals (2 meals at 6 months, then 3 meals and 2 snacks each day, in addition to continued breastfeeding from 6-9 months, and 3-4 meals and 1-2 snacks plus breastfeeding for 9 months- 2 years of age).

- **Pregnancy mothers need extra meal and extra rest**

Step 3: Discussion on Key feeding behaviors

- You should use a participatory style (no lectures) to talk about the topic focus,.
- You can answer questions that pregnant women have about this,
- Your role is to make these mothers realize that it is possible for them to do this at home!

Step 4: Review and Discuss the Lesson for the Day

- Why is important to feed pregnant women animal-source food and fat?
- Why is necessary to feed a children animal –source food and fat? Where can we get some animal source food to feed the child some every day?
- What do you need to do before you begin to cook and eat?
- Why is important to mash the meal of the child?

Main Messages:

- ✓ The children need fat; animal source food to build a body and iron to prevent anemia
- ✓ A pregnant women need to eat more fat and extra meal and extra rest.

Step 5: Prepare for the next day

- Decide who is bringing what foods, materials
- Closure and NW song.

DAY 3: MAIN TOPIC - FREQUENCY OF MEALS

FOUR TO FIVE TIMES EACH DAY

Training Objectives

At the end of this topic, the participants will be able

- To feed more frequent meals and snacks (3 meals and 1-2 snacks per day, in addition to continued breastfeeding), and to have a separate cup for feeding the child
- To prepare and to feed thicker porridge to their children starting at six months of age
- To wash their hands regularly the four recommended key times
- To take an extra rest and an extra meal for pregnancy mothers

Methods

- Brainstorming
- Group work

Materials and Tools

1. Cooking supplies:

Wood for fire (and matches)	Tomatoes
2 Pans (for making porridge and food)	Amaranths (green leafy vegetables)
Jerry cans to transport water	Carrots
Flour for porridge	Onions
Big Spoon (for cooking)	Green pepper
Oil	Irish potatoes
rabbit meat (or small whole fish pounded)	Snacks for small children (Passion fruit)
Soap, sponges, and tubs for washing dishes	

2. Counseling card for MIYCN

Introduction

- Opening & Welcome mothers and mothers in law
- Attendance **,**
- **check children for sickness** (refer to HC if they are sick)
- Review nutrition week and topic of Yesterday and introduce the Topic for the Day

Review of yesterday topic*:* Eating fat and animal source food

ASK : What is the importance of fats for child?

ASK : What is the importance of animal's source foods for a child?

ASK: Give us some available foods which contain high amount fats and animal's source food?

ASK : can children more than 6 months of age eat animal-source foods? (Yes- Breastmilk!)

ASK : Child more than 6 month can eat oil?

TELL them:

- ✓ Child must eat animal- source food to build a body and to prevent anemia.
- ✓ Mothers and children need to eat more fat and animal source food to build a body and to prevent anemia.

Topic for the day: Feeding children more times per day

Facilitator Information

The WHO Guiding principles for Complementary Feeding say this about Feeding Frequency:

Start at six months of age with small amounts of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding. The energy needs from complementary foods for infants with "average" breast milk intake in developing countries (WHO/UNICEF, 1998) are approximately 200 kcal per day at 6-8 months of age, 300 kcal per day at 9-11 months of age, and 550 kcal per day at 12-23 months of age.) This is based on children receiving average amounts of breast milk at each age. If an infant is consuming more or less breast milk than the average, the amount needed from complementary foods will differ accordingly. In practice, caregivers will not

know the precise amount of breast milk consumed, nor will they be measuring the energy content of complementary foods to be offered. **Thus, the amount of food to be offered should be based on the principles of responsive feeding**, while assuring that energy density and meal frequency are adequate to meet the child's needs.

The Rwanda MIYCN messages are:

0-6 months Exclusive Breastfeeding only

at 6 months start 2 meals of soft porridge, in addition to breastfeeding and 1-2 snacks per day.

6- 9 months: 2-3 meals and 1-2 snacks plus continued breastfeeding.

9- 24 months: 3-4 meals, 1-2 snacks and continued breastfeeding.

TELL them:

- ✓ Children's stomachs are only the size of their fist, and so they need to eat more often! Adult's stomachs are bigger, so we can eat less frequently.
- ✓ Eating five times per day will make sure they get enough food for the day, and to sleep better.
- ✓ Also good to bring up here the use of a child's bowl- to wash and use separately to keep track of how much is fed to the child.

Step 1: Practice new cooking and child feeding behaviors

- **Collect food and materials** that women brought for third day.
- **3 Group discussions about to the frequency of meal per day**

ASK : What frequency per day do you feed your child of 6 months of age?

RESPONSE: *At 6 months you start with 2 meals of soft porridge per day, and 1-2 snacks as needed, it is important to keep breastfeeding*.

ASK : What frequency per day do you feed your child of 6 months to 9 months of age?

RESPONSE: *You gradually make porridge thicker and increase meals to 3 per day and 1-2 snacks per day and continued breastfeeding*

ASK : What frequency per day do you feed your child of 9 months to 24 months of age?

RESPONSE: *3-4 meals, 1-2 snacks and continued breastfeeding*

After group discussion, and presentation in large group tell them:

- Child aged between 6 months and 9 months must feed 2meals and 1-2 snacks and continued breastfeeding

- Child aged between 9months - 24 months must feed 3 meals and 1-2 snacks and continued breasfeeding

The texture is also important to guide nutrients

Tell them also about texture:

- ✓ For child of 6 months and 9 months, meals is like thicker porridge (pureed food)
- ✓ For child of 9 months and 12 months, meals is like finger food, sliced food, but can also be a very thick porridge with extra ingredients like vegetables and animal source foods.
- ✓ For child of 12 month and 24 months, meals is like family food (it can be mashed or cut up in small pieces) or sliced food

Step 2: Hygiene Practice

- ✓ Clean up the children-hand washing, etc.
- ✓ Cleaning Dishes (use of dish racks to keep clean)

Getting ready to feed children— *split the group of mothers into three sub groups:*

- one group responsible for looking after kids,

- one group for getting water to cook,
- one group responsible for starting the fire to cook over

Wash Hands

- As they go to wash their hands, this is an opportunity to talk about the 4 times that you need to wash your hands: before cooking, before feeding the baby, after attending a child, after using the toilet.
- Ask the mothers when they need to do this, use this time as a learning and discussion opportunity as they are washing their hands

Small snacks for children— Papaya (mango not available)

Cooking thick porridge and meal

Cooking the daily recipe (whatever food is brought will create the day's recipe)

Cook the food, following recipes, and including mothers and mothers-in-law as much as possible. (It is the recipes we prepared for NW, we used the same for PD Hearth. MOH did not plan the recipes but we are supporting the MOH to develop some recipes that should be used at community level.)

While you are cooking, there will be time for you to answer questions that mothers have about the topic for the day!

Ingredients *(amounts will depend on number of servings)*

Tomatoes	Soy flour
Amaranths (green leafy vegetables)	Salt
Small Fish, and other animal source foods if possible (egg, organ meat, etc.)	Green
Oil	Pepper
Banana plant	Passion fruits
Carrots	Avocado
Onions	

Directions for cooking

- ✓ Clean vegetables and remove skins from the banana plant, soak small fish in cold water for 5 minutes
- ✓ Boil pot of water
- ✓ Add banana plant, boil for 15 min.
    - ✓ Reduce Heat and Add all vegetables, small fish and oil, stirring and cooking for 15 minutes
    - ✓ Add a small amount of salt after vegetables have been cooking for five minutes.
    - ✓ After vegetables have been cooking for 15 minutes (30 minutes total including the sliced potatoes), take off heat for serving
    - ✓ Mash up cooked food, and then serve to children on clean plates, with clean spoons—with one passion fruit and a slice of avocado.

- ***Feed the children :*** *ask mothers in-law help mothers to feed the child*

Reminder the mothers and mother's in-law the active feeding:

- ➢ Help your older child eat.
- ➢ Use a separate plate to feed the baby to make sure he or she eats all the food given

Step 3: Discussion on Key feeding behaviors (frequency of meal).

Instructions for teaching

- ✓ You should use a participatory style (no lectures) to talk about the day's focus. You can answer questions that mothers or mothers-in-law have about this, talk about problems that mothers and mothers–in-law have to providing 5 meals for their children every day.
- ✓ Your role is to make these mothers and mothers–in-law realize that it is possible for them to do this at home!
- ✓ The point of this day is to involve the mothers and mothers-in-law as much as possible. By practicing this every day, it helps them to understand the practice and make it a good habit.
- ✓ Talk about how to plan a menu for five meals, and have women give ideas and tell how they would do it.

Step 4: Review and Discuss the Lesson for the Day

- ✓ Why is increased frequency (five times per day) important?
- ✓ What do you need to do before you begin to cook and eat?
- ✓ Why is important to mash the meal of the child?

Step 5: Prepare for the next day: Who is bringing what foods, materials.

DAY 4: MAIN TOPIC: EVERYONE NEEDS TO EAT A VARIETY OF FOODS

Training Objectives

At the end of this topic the participants will be able to:

- To prepare a variety of foods for their child.
- To feed more frequent meals (ONLY Breastmilk 0-6 months, then continue breastfeeding until 2 years of age. At 6 months start 2 start 2 small meals and 1-2 snacks per day. By 9 months offer 2-3 meals and 1-2 snacks. From 9-24 months offer continued breastfeeding, 3-4 meals and 1-2 snacks. It is also important to have a separate cup for feeding the child to see how much they have eaten.
- To prepare and to feed thicker porridge to their children starting at six months of age
- To wash regularly their hands at the four recommended key times
- To take an extra rest and an extra meal for pregnancy mothers

Methods

- Asking questions (brainstorming questions)
- Small Group discussions

Materials and Tools

1. Cooking supplies:

Wood for fire (and matches)	Tubs
Pans for making porridge	Tomatoes
Water	Cabbage
Flour for porridge	Salt
Cups/plates for serving	Potatoes
Oil	Onions
Small fish	Beans
Jerry cans	Green Pepper
Green Leaves	Avocado

2. Counseling card for MIYCN

Introduction

- Opening & Welcome mothers and fathers
- Attendance
- **check children for sickness** (refer to HC if they are sick)
- Introduce review for Yesterday topic and Topic for the Day (Everyone needs a variety of foods)

Topic for Yesterday: Feeding children 3-4 meals, 1-2 snacks and continued breastfeeding

Reminder mothers and fathers about frequency of meals

- ✓ Child aged between 6 months and 9 months must be fed 2-3 big meal and 1-2 snacks
- ✓ Child aged between 9months and 12 months must be fed 3-4 big meal and 1-2 snacks
- ✓ Child aged between 12 months-24 months must be fed 3-4 big meal and1-2 snacks
- ✓ Children's stomachs are only the size of their fist, and so they need to eat more often! Adult's stomachs are bigger, so we can eat less frequently.
- ✓ Eating five times per day will help them to fill their stomachs, and to sleep better.
- ✓ Also good to bring up here the use of a child's bowl- to wash and use separately to keep track of how much is fed to the child.

Topic for the day: Everyone needs a variety of foods

Teaching Notes

- This day is going to be different than the three days beforehand. While you are going to introduce the topic, you will also be taking a trip to visit the best kitchen garden in your village, so that mothers and fathers can see what they look like, how to tend them, and how they can be a good source of fresh, nutrient-rich food for their families.

Key Points to Emphasize

- ✓ Eating a variety of foods will help you and your child to be strong and live a healthy life.
- ✓ Your children need the nutrients that come from eating a variety of foods. This will help to build their immunity and help them to grow strong.

Step 1: Visit the best kitchen garden in your village

- Introduce the topic in a few minutes, and take the time you would use to have small group discussions to walk to the kitchen garden, where you can practice together.
- As you walk to and from the best garden in the village, use the time to answer questions that the mothers may have, to talk with them about any problems they may have in planting a kitchen garden or providing a variety of foods for their children.
- When you get to the garden, the owner of the garden explain to the mothers how to plant one, how to tend it, how to water it (in the dry season, for example, use the rinse water from washing your clothes.
- Splits the participants into two groups, mothers group and fathers group.
- Group discussion about links between kitchen garden and varied foods.

Step 2: Hygiene Practice

- Clean up the children-hand washing, etc.
- Cleaning Dishes (use of dish racks to keep clean)
- Wash Hands, (as they go to wash their hands, this is an opportunity to talk about the 4 times that you need to wash your hands: before cooking, before feeding the baby, after attending a child, after using the toilet.
- Ask the mothers when they need to do this, use this time as a learning and discussion opportunity as they are washing their hands

Step 3: Interactive practices on Cooking and child feeding

Upon returning, collect food and materials that women brought for the day. (Because the visit to the garden will take so much time, could the mothers-in-law or a few women who know how to garden stay behind to cook the meal? This way it will be mostly done and those who cooked can just explain what all they put in the pot and how they did it. The recipe is very similar to the two previous days so they will know how.)

Getting ready to feed children— split the group of mothers and fathers into three sub groups:

- one group responsible for looking after kids
- one group for getting water to cook

- one group responsible for starting the fire to cook over

- **Wash Hands (**As they go to wash their hands, this is an opportunity to talk about the 4 times that you need to wash your hands: before cooking, before feeding the baby, after attending a child, after using the toilet.)

INSTRUCTION: *Since this is the first time fathers are hearing this message, it will be good to spend a bit more time on WHY it is important.*

- **ASK**: The mothers when they need to do this, use this time as a learning and discussion opportunity as they are washing their hands.

- **Small snacks for children**— Small bananas (they can wash hands as they arrive and eat the snack, before going to the garden.)

INSTRUCTION*: Try to involve fathers as much as possible; ask dads to wash their hands and to give the snacks to the children*

Cooking the daily recipe (whatever food is brought will create the day's recipe)

- While you are cooking, there will be time for you to answer questions that mothers and fathers have about day's topic.

- Have the mothers participate as much as possible (peeling and chopping vegetables, tending the pot).

- Discuss how the fathers can be involved in finding a variety of foods to feed the whole family—because everyone needs to eat variety of foods! To help mothers and fathers understand that their children (beginning at six months) need and can eat a variety of foods at each meal (and it will help them be healthier, grow, and fight against disease). Some examples include animal source foods (eggs, small fish), staples (sorghum, wheat, maize, rice), tubers (potato, cassava, sweet potato), legumes, and fruits and vegetables, especially those rich in vitamin A.

Ingredients *(amounts will depend on number of servings)*

Tomatoes	Onions
Cabbage	Beans

Guinea Pig	Salt
Oil	Green Pepper
Potatoes	Green Leaves

Directions for cooking

- Clean vegetables and remove skins from the potatoes, soak small fish in cold water for 5 minutes
- Boil pot of water
- Add potatoes, boil for 15 min.
- Reduce heat and add all vegetables, small fish and oil, stirring and cooking for 15 minutes
- Add a small amount of salt after vegetables have been cooking for five minutes.
- After vegetables have been cooking for 15 minutes (30 minutes total including the potatoes), take off heat for serving
- Mash up cooked food, then serve to child on a clean plate, with a clean spoon—with a slice of avocado.
- **Feed the children (Fathers can practice, if possible)**

Reminder the mothers and fathers the active feeding:

- ✓ Help your child eat.
- ✓ Use a separate plate to feed the children to make sure he or she eats all the food given

Step 4: Discussion on Key feeding behaviors (Emphasis on a variety of foods).

Instructions for teaching

- ✓ You should use a participatory style (no lectures) to talk about the recipes and behaviors you have been using and practicing.
- ✓ Try to ask the mothers and fathers about frequency of meals and eating a variety of foods, choose one mother at random to explain how she would prepare five varied meals for a child in one day (3 meals and two snacks).
- ✓ By doing this, you will help her to see how it is possible for her to try doing this at home

- ✓ Your role is to make these mothers and fathers motivated to try something new. Ask them if it's possible for them to do this at home.

- ✓ The point of this day is to involve the mothers and fathers as much as possible, practicing a new behavior so that it becomes part of normal, everyday practice.

Key Points to Emphasize

- Eating a variety of foods will help you and your child to be strong and live a healthy life.

- Your children need the nutrients that come from eating a variety of foods. This will help to build their immunity and help them to grow strong.

Step 5: Review and Discuss the Lesson for the Day

- Why is it important for children to eat a variety of foods?

- Why do we all need to eat varied foods?

- What do you need to do before you begin to cook and eat?

- What are the links between frequency of meals and eating a variety of foods?

Step 6: Prepare for the next day: Who is bringing what foods, materials.

DAY 5: MAIN TOPIC– CHILDREN NEED INFANT STIMULATION/ ACTIVE FEEDING and Pregnant women need an extra meal and rest

Training Objectives

At the end of this topic the participants will be able to:

- To practice active feeding to their child
- To prepare a variety of foods for their child.
- To feed more frequent meals (four-five each day, as well as breastfeeding still), and to have a separate cup for eating.
- To prepare and to feed thicker porridge to their children which starting at six months of age
- To wash regularly their hands at four recommended key times
- To take an extra rest and an extra meal for pregnancy mothers

Methods

- Small Group discussions
- Asking questions (both direct and brainstorming questions)
- Using props and visual examples (including visuals and explanations from cooking demonstration)

Materials and tools

1.Cooking supplies:

Flour for porridge	Water	Green Leaves
Spoon	Potatoes	Avocado
Oil	Dodo	Pans for making porridge
Small fish	Tomatoes	Snacks for small children (small bananas
Wood for fire (and matches)	Salt	

2. Counseling card for MIYCN

Introduction

- Opening & Welcome mothers and fathers
- Attendance
- **check children for sickness** (refer to HC if they are sick)
- Introduce review for Yesterday topic and Topic for the Day (Everyone needs a variety of foods, and why pregnant women needs extra food and rest.)

Topic for Yesterday: Every one needs a variety of foods

Reminder mothers and fathers all six kind of food

- Children over six months need to eat variety of foods at each meal (and it will help them be healthier, grow, and fight against disease).). Some examples include animal source foods (eggs, small fish), staples (sorghum, wheat, maize, rice), tubers (potato, cassava, sweet potato), legumes, and fruits and vegetables, especially those rich in vitamin A. Eating a variety of foods will help you and your child to be strong and live a healthy life.
- Your children need the nutrients that come from eating a variety of foods. This will help to build their immunity and help them to grow strong.

Topic for the day: Children need infant stimulation/active feeding and
Pregnant women need an extra meal and rest

Step 1: Practice on cooking, child feeding and pregnant mother nutrition

Divide up the participants in 2 working groups one for mothers and other for fathers

ASK : what is active feeding and some practice of it.
ASK : why pregnant women need an extra meal and rest?
ASK : What can you do if your child refuses to eat?
ASK : What can you do if your child lacks appetite such as when He / She is sick?
ASK : why do pregnant women need an extra meal and rest?

After the presentation, discuss in large group,

TELL them:

Active Feeding:

- ✓ Baby may need time to get used to eating foods other than breast milk.
- ✓ Be patient, actively encourage your baby to eat, but do not force him or her to eat.
- ✓ Use a separate plate to feed the baby to make sure he or she eats all the food given
- ✓ If your young child refuses to eat, encourage him/her repeatedly, try holding the child in your lap during feeding, or face him/her while he or she is sitting on some one else's lap.
- ✓ Offer new foods several times, children may not like (or accept) new foods in the first few tries.
- ✓ Feeding times are periods of learning and love.
- ✓ Interact and minimize distraction during feeding.
- ✓ Don't force feed.
- ✓ Help your older child eat.

Pregnant women need an extra meal:

- ➢ During your pregnancy, eat one extra meal each day to provide energy and nutrition for you and your growing baby.
- ➢ You need to eat the best nutritious foods available, including milk, fresh fruit and vegetables, peas and beans, the extra meal will help your baby grow.

Pregnant women need an extra rest

- ➢ You need extra rest than women, you need to nourish your own body, which is still have a baby, as well as your growing baby's.
- ➢ To avoid hard work. Your role is to make these mothers realize that it is possible for them to do this at home in order to become a habit.

The point of day is to involve the fathers and mothers as much as possible to become the part of normal.

To involve the fathers as much as possible allow pregnant women an extra rest and also extra meal Discuss how the fathers can be involved in finding the extra rest for their wife.

Discuss how the fathers can be involved in doing active feeding—making sure that they are doing so when they are taking care of the children.

Step 2: Hygiene Practice

- Clean up the children-hand washing, etc.
- Cleaning Dishes (use of dish racks to keep clean)
- **Wash Hands (**As they go to wash their hands, this is an opportunity to talk about the 4 times that you need to wash your hands: before cooking, before feeding the baby, after attending a child, after using the toilet.)
- Ask the fathers and mothers when they need to do this, use this time as a learning and discussion opportunity as they are washing their hand split the group of mothers and fathers into three sub groups

Step 4: Cooking the daily recipe (whatever food is brought will create the day's recipe)

- Split the group of mothers and fathers into three sub groups
    - one group responsible for looking after kids,
    - one group for getting water to cook,
    - group responsible for starting the fire to cook over

- **Small snacks for children**— Small bananas

- While you are cooking, there will be time for you to answer questions that mothers and fathers have about day's topic

- Discuss how the fathers can be involved in finding the extra rest for their wife.

Step 5: Discussion on Key feeding behaviors

Reminder the mothers and fathers the active feeding:

- ✓ Baby may need time to get used to eating foods other than breast milk.
- ✓ Be patient, actively encourage your baby to eat, but do not force him or her to eat.
- ✓ Use a separate plate to feed the baby to make sure he or she eats all the food given
- ✓ If your young child refuses to eat, encourage him/her repeatedly, try holding the child in your lap during feeding, or face him/her while he or she is sitting on some one else's lap.

- ✓ Offer new foods several times, children may not like (or accept) new foods in the first few tries.
- ✓ Feeding times are periods of learning and love. Also, your baby is learning to trust you, and wants to please you, so we need to be patient.
- ✓ Interact and minimize distraction during feeding.
- ✓ Don't force feed.
- ✓ Help your older child eat.

Key Points to emphasize

- *Children need infant stimulation/active feeding*
- *Pregnancy mother need an extra meal and rest*

Step 6: Review and Discuss the Lesson for the Day

ASK : Why Children need infant stimulation/ active feeding ?

ASK : Why pregnant women need an extra meal and rest ?

ASK : What do you need to do before you begin to cook and eat?

Step 7: General review, closure and NW song.

- To feed more frequent meals (three meals and 2 snacks and continued breastfeeding), and to have a separate cup for eating.
- To prepare and to feed thicker porridge to their children which starting at six months of age
- To wash regularly their hands at four recommended key times
- To take an extra rest and an extra meal for pregnancy mothers

Step 8: Tell them the next steps:

- ❖ MUAC SCHEDULE FOR MOTHERS
- ❖ MUAC & WEIGHING SCHEDULE FOR CHILDREN
- ❖ TWO MONTHS OF FOLLOW UP

Annex 10: Supervisory Checklist for Nutrition Weeks Implementation

GENERAL INFORMATION			
DATE:	**SUPERVISOR:**		
Village:	**No NW Site:**		
NW Day:	**Total Number of Participants:**		
# Participants/ Categories #Lactating Mothers : #Pregnant Women: #Fathers : #Grandmothers:			
ITEMS TO CHECK	**PRESENT?**		**COMMENTS**
	YES	**NO**	
NW Site : Environmental cleanliness Presence of soap and water Spacious and clean kitchen area Mats or Bench for participants to sit on			
NW Meal : Food contribution from each participant Ingredients contributed by NGO or others Consistency and variety of food Fat or Oil in meal Animal Source food Snacks provided			
Caregiver practices Hand washing before processing food Washing children's hands and face before and after feeding Processing foods Help children to self-feeding Good caregiver-child interaction in games and in			

general			
CHW or Local Leader Skills Supervising mothers (participants) at processing and cooking Encouraging good interactions parent-child Good communication skills Use properly the NW training Module Record keeping			
Caregiver knowledge, attitude and practice: Understanding of the NW Goals Reported behavior change			
Discussion of special topics (health education)			
Other topics			

Annex 11: Project Data Form

Child Survival and Health Grants Program Project Summary

Oct-25-2012

World Relief Corporation (Rwanda)

General Project Information

Cooperative Agreement Number:	AID-OAA-A-11-00056
WRC Headquarters Technical Backstop:	
WRC Headquarters Technical Backstop Backup:	Olga Wollinka
Field Program Manager:	Grace Umutoni
Midterm Evaluator:	
Final Evaluator:	
Headquarter Financial Contact:	Rachel Hower
Project Dates:	10/1/2011 - 9/30/2015 (FY2011)
Project Type:	Innovation
USAID Mission Contact:	Patrick M. Condo
Project Web Site:	

Field Program Manager

Name:	Grace Umutoni
Address:	
	Rwanda
Phone:	
Fax:	
E-mail:	gumutoni@wr.org
Skype Name:	

Alternate Field Contact

Name:	Melene Kabadege (MCH Regional Technical Advisor)
Address:	Box 6052
	Kigali Rwanda
Phone:	250.(0)78.830.6586
Fax:	
E-mail:	mkabadege@wr.org
Skype Name:	melene571

Grant Funding Information

USAID Funding: $1,750,000 **PVO Match:** $583,333

General Project Description

World Relief is implementing a child survival project in Nyamagabe District, Rwanda. The project goal is to reduce morbidity, mortality and underlying malnutrition of children under five and pregnant women. Project resources will build the capacity of Ministry of Health (MOH) staff to train and supervise government-sanctioned community health workers (CHWs) in the implementation of their community-based packages.

Integration of interventions at community level and local problem solving will be enhanced by forming the CHWs into Modified Care Groups with additional members drawn from local and religious leaders and members of the Hygiene Club executive committees. CHWs will retain their specialized responsibilities, as defined by the MOH, yet they will work together with the additional CG members to more effectively mobilize the communities for behavior change and appropriate care seeking by dividing up the village geographically amongst themselves to facilitate more regular home visits.

The project's Strategic Objective is "improved capacity of MOH staff and CHWs to implement high impact maternal, newborn and child health interventions at the community level." The project's intermediate results are:

IR 1) Improved geographic access to and demand for high quality MNCH services;

IR 2) Improved coordination of and impact of community health activities; and

IR 3) Innovation tested to improve the effectiveness of the Community Based Nutrition Program.

Project Location

Latitude: -1.94	**Longitude:** 39.87
Project Location Types:	Rural
Levels of Intervention:	Health Center Health Post Level Home Community District Hospital Other: National MOH
Province(s):	Southern Province
District(s):	Nyamagabe District
Sub-District(s):	Kaduha Hospital Catchment area Kigeme Hospital Catchment area

Operation: Research Information

OR Project Title:	Nutrition Weeks addition to Rwanda MOH CBNP Program for malnutrition prevention in first 1000 days.
Cost of OR Activities:	$175,917
Research Partner(s):	PI Dr. Judy McLean, PhD, Assistant Professor, Univ of British Columbia, Vancouver; Co-PI:Dr. Fidele Ngabo, MD, MSc, PhD Candidate, Director of MCH Unit; Co-Investigator and author of Nutrition Weeks: Melene Kabadeghe, WR Regional Technical Advisor;Co-I: Alphonsine Nyirahabineza, MOH Nutrition Head
OR Project Description:	Given the high prevalence of undernutrition and stunting in Rwanda, this operational research study aims to**identify** the most feasible way to reduce and prevent undernutrition in the first 1000 days of life of children in Nyamagabe District, Rwanda through formative research, and then to**test** the innovated intervention, namely, **"Nutrition Weeks"** to evaluate if the intervention is more effective than the standard Community-based Nutrition Program which uses education and cooking demonstrations. "Nutrition Weeks" are a hybrid of PD/Hearth and Care Groups, with a focus on preventing malnutrition through three-times per year Hearth-like community-based learning sessions led by trained (CHWs), and supervised by MOH and WR. The assessment will include an evaluation of the effects through anthropometry and KPCs, CHW interviews to assess additional cost, effort and time involved, changes in health practices and child growth outcomes through maternal exit interviews, and feasibility of scale-up.

Partners:

Ministry of Health (Collaborating Partner)	$0
District of Nyamagabe (Collaborating Partner)	$0

Strategies

Social and Behavioral Change Strategies:	Community Mobilization Group interventions Interpersonal Communication
Health Services Access Strategies:	Addressing social barriers (i.e. gender, socio-cultural, etc) Community-based health insurance scheme/Community financing mechanisms Implementation with a sub-population that the government has identified as poor and underserved Implementation in a geographic area that the government has identified as poor and underserved
Health Systems Strengthening:	Quality Assurance Conducting capacity assessment of local partners Supportive Supervision Task Shifting Developing/Helping to develop clinical protocols, procedures, case management guidelines Developing/Helping to develop job aids Referral-counterreferral system development for CHWs Community role in supervision of CHWs Community role in recruitment of CHWs Coordinating existing HMIS with community level data Performance-based incentives or contracts for health facility workers
Strategies for Enabling Environment:	Create/Update national guidelines/protocols Advocacy for revisions to national guidelines/protocols Stakeholder engagement and policy dialogue (local/state or national) Advocacy for policy change or resource mobilization
Tools/Methodologies:	BEHAVE Framework Community-based Monitoring of Vital Events LQAS Mobile Devices for Data Collection

Capacity Building

Local Partners:	National Ministry of Health (MOH) Dist. Health System Health Facility Staff Government sanctioned CHWs

Intervention: & Component:

Control of Diarrheal Diseases (15%) - Water/Sanitation - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Care Seeking - Case Management/Counseling - POU Treatment of water - Zinc - Community Case Management with Zinc (Implementation) - Community Case Management with ORS (Implementation)	IMCI Integration	CHW Training HF Training
Infant & Young Child Feeding - ENA - Gardens - Comp. Feed. from 6 mos. - Cont. BF up to 24 mos. - Growth Monitoring - Maternal Nutrition - Promote Excl. BF to 6 Months	IMCI Integration	CHW Training HF Training
Maternal & Newborn Care (35%) - Recognition of Danger signs - Newborn Care - Post partum Care - Child Spacing - Integration. with Iron & Folic Acid - Normal Delivery Care - Birth Plans - Emergency Transport	IMCI Integration	CHW Training HF Training
Pneumonia Case Management (10%) - Case Management Counseling - Recognition of Pneumonia Danger Signs - Community Case Management with Antibiotics (Implementation)	IMCI Integration	CHW Training HF Training

Operational Plan Indicators:

Number of People Trained in Maternal/Newborn Health			
Gender	Year	Target	Actual
Female	2012	1608	
Male	2012	1608	
Female	2013	2144	
Male	2013	1608	
Number of People Trained in Child Health & Nutrition			
Gender	Year	Target	Actual
Female	2012	1608	
Male	2012	1608	
Female	2013	1608	
Male	2013	1608	
Number of People Trained in Malaria Treatment or Prevention			
Gender	Year	Target	Actual
Female	2012	0	
Male	2012	0	
Female	2013	0	
Male	2013	0	

Locations & Sub-Areas:

Kaduha Hopital catchment area of Nyamagabe District	159,195
Kigeme Hospital Catchment area of Nyamagabe District	166,581
Total Population:	325,776

Target Beneficiaries:

	Kaduha Hopital catchment area of Nyamagabe District	Kigeme Hospital Catchment area of Nyamagabe District	Total
Children 0-59 months	20,218	21,096	41,314
Women 15-49 years	54,531	56,900	111,431
Beneficiaries Total	74,749	77,996	152,745

Rapid Catch Indicators: DIP Submission

Sample Type: 30 Cluster

Antenatal Care

Description – Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child

Numerator: Enter the number of mothers with children age 0-23 months who had at least four antenatal visits while pregnant with their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	163	358	45.5%	7.3
Kigeme Hospital Catchment area of Nyamagabe District	176	360	48.9%	7.3

Maternal TT Vaccination

Description – Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child

Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	245	358	68.4%	6.8
Kigeme Hospital Catchment area of Nyamagabe District	246	360	68.3%	6.8

Skilled Birth Attendant

Description – Percentage of children age 0-23 months whose births were attended by skilled personnel

Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary midwife, or other personnel with midwifery skills

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	297	358	83.0%	5.5
Kigeme Hospital Catchment area of Nyamagabe District	330	360	91.7%	4.0

Current Contraceptive Use Among Mothers of Young Children

Description – Percentage of mothers of children age 0-23 months who are using a modern contraceptive method

Numerator: Enter the number of mothers with children age 0-23 months who are using a modern contraceptive method

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	205	358	57.3%	7.2
Kigeme Hospital Catchment area of Nyamagabe District	225	360	62.5%	7.1

Post-Natal Visit to Check on Newborn Within the First 2 Days After Birth

Description – Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth

Numerator: Enter the number of children age 0-23 months who received a post-natal visit within two days after birth by an appropriate health worker

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	135	358	37.7%	7.1
Kigeme Hospital Catchment area of Nyamagabe District	159	360	44.2%	7.3

Exclusive Breastfeeding

Description – Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours

Numerator: Enter the number of children age 0-5 months who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours

Denominator: Enter the total number of children age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	82	90	91.1%	8.3
Kigeme Hospital Catchment area of Nyamagabe District	89	90	98.9%	3.1

Infant and Young Child Feeding

Description – Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Numerator: Enter the number infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	8	270	3.0%	2.9
Kigeme Hospital Catchment area of Nyamagabe District	9	270	3.3%	3.0

Vitamin A Supplementation in the Last 6 Months

Description -- Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall

Numerator: Enter the number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mother's recall or card verified)

Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	190	270	70.4%	7.7
Kigeme Hospital Catchment area of Nyamagabe District	208	270	77.0%	7.1

Measles Vaccination

Description -- Percentage of children age 12-23 months who received a measles vaccination

Numerator: Enter the number of children age 12-23 months who received a measles vaccination by the time of the interview as seen on the card or recalled by the mother

Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	139	159	87.4%	7.3
Kigeme Hospital Catchment area of Nyamagabe District	121	145	83.4%	8.6

Access to Immunization Services

Description -- Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	142	159	89.3%	6.8
Kigeme Hospital Catchment area of Nyamagabe District	126	145	86.9%	7.8

Health System Performance Regarding Immunization Services

Description -- Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received DTP3 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	134	159	84.3%	8.0
Kigeme Hospital Catchment area of Nyamagabe District	122	145	84.1%	8.4

Treatment of Fever in Malarious Zones

Description -- Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began

Numerator: Enter the number of children age 0-23 months with a febrile episode in the last two weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug

Denominator: Enter the total number of children age 0-23 months with a febrile episode in the last two weeks

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	11	75	14.7%	11.3
Kigeme Hospital Catchment area of Nyamagabe District	1	86	1.2%	3.2

ORT Use

Description -- Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids

Numerator: Enter the number of children age 0-23 months with diarrhea in the last two weeks AND who received oral rehydration solution (ORS) and/or recommended home fluids

Denominator: Enter the total number of children age 0-23 months who had diarrhea in the last two weeks

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	15	65	23.1%	14.5
Kigeme Hospital Catchment area of Nyamagabe District	16	70	22.9%	13.9

Appropriate Care Seeking for Pneumonia

Description -- Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Numerator: Enter the number of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Denominator: Enter the total number of children with chest-related cough and fast and /or difficult breathing in the last two weeks

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	38	86	44.2%	14.8
Kigeme Hospital Catchment area of Nyamagabe District	51	113	45.1%	13.0

Point of Use (POU)

Description – Percentage of households of children age 0-23 months that treat water effectively

Numerator: Enter the number of households of mothers of children 0-23 months that treat water effectively

Denominator: Enter the total number of households of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	180	360	50.0%	7.3
Kigeme Hospital Catchment area of Nyamagabe District	203	360	56.4%	7.2

Appropriate Hand Washing Practices

Description – Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing

Numerator: Enter the number of mothers with children age 0-23 months who live in households with soap at the place for hand washing

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	139	360	38.6%	7.1
Kigeme Hospital Catchment area of Nyamagabe District	158	360	43.9%	7.2

Child Sleeps Under an Insecticide-Treated Bednet

Description – Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night

Numerator: Enter the number of children age 0-23 months who slept under an insecticide-treated bednet the previous night

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	241	360	66.9%	6.9
Kigeme Hospital Catchment area of Nyamagabe District	241	360	66.9%	6.9

Underweight

Description – Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)

Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference population

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District	64	359	17.8%	5.6
Kigeme Hospital Catchment area of Nyamagabe District	32	359	8.9%	4.2

Rapid Catch Indicators: Mid-term

Sample Type:

Antenatal Care

Description – Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child

Numerator: Enter the number of mothers with children age 0-23 months who had at least four antenatal visits while pregnant with their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Maternal TT Vaccination

Description – Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child

Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Skilled Birth Attendant

Description – Percentage of children age 0-23 months whose births were attended by skilled personnel

Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary midwife, or other personnel with midwifery skills

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Current Contraceptive Use Among Mothers of Young Children

Description – Percentage of mothers of children age 0-23 months who are using a modern contraceptive method

Numerator: Enter the number of mothers with children age 0-23 months who are using a modern contraceptive method

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Post-Natal Visit to Check on Newborn Within the First 2 Days After Birth

Description – Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth

Numerator: Enter the number of children age 0-23 months who received a post-natal visit within two days after birth by an appropriate health worker

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Exclusive Breastfeeding

Description – Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours

Numerator: Enter the number of children age 0-5 months who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours

Denominator: Enter the total number of children age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Infant and Young Child Feeding

Description – Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Numerator: Enter the number infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Vitamin A Supplementation in the Last 6 Months

Description – Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall

Numerator: Enter the number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mother's recall or card verified)

Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Measles Vaccination

Description – Percentage of children age 12-23 months who received a measles vaccination

Numerator: Enter the number of children age 12-23 months who received a measles vaccination by the time of the interview as seen on the card or recalled by the mother

Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Access to Immunization Services

Description – Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Health System Performance Regarding Immunization Services

Description – Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received DTP3 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Treatment of Fever in Malarious Zones

Description – Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began

Numerator: Enter the number of children age 0-23 months with a febrile episode in the last two weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug

Denominator: Enter the total number of children age 0-23 months with a febrile episode in the last two weeks

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

ORT Use

Description – Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids

Numerator: Enter the number of children age 0-23 months with diarrhea in the last two weeks AND who received oral rehydration solution (ORS) and/or recommended home fluids

Denominator: Enter the total number of children age 0-23 months who had diarrhea in the last two weeks

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Appropriate Care Seeking for Pneumonia

Description – Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Numerator: Enter the number of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Denominator: Enter the total number of children with chest-related cough and fast and /or difficult breathing in the last two weeks

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Point of Use (POU)

Description -- Percentage of households of children age 0-23 months that treat water effectively

Numerator: Enter the number of households of mothers of children 0-23 months that treat water effectively

Denominator: Enter the total number of households of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Appropriate Hand Washing Practices

Description -- Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing

Numerator: Enter the number of mothers with children age 0-23 months who live in households with soap at the place for hand washing

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Child Sleeps Under an Insecticide-Treated Bednet

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night

Numerator: Enter the number of children age 0-23 months who slept under an insecticide-treated bednet the previous night

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Underweight

Description -- Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)

Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference population

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Rapid Catch Indicators: Final Evaluation

Sample Type:

Antenatal Care

Description – Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child

Numerator: Enter the number of mothers with children age 0-23 months who had at least four antenatal visits while pregnant with their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Maternal TT Vaccination

Description – Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child

Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Skilled Birth Attendant

Description – Percentage of children age 0-23 months whose births were attended by skilled personnel

Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary midwife, or other personnel with midwifery skills

Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
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Description – Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)

Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference population

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Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Kaduha Hopsital catchment area of Nyamagabe District			%	
Kigeme Hospital Catchment area of Nyamagabe District			%	

Rapid Catch Indicator Comments

The Rapid CATCH indictor for malaria treatment is defined as children with fever who received an antimalarial drug within 24 hours. According to this definition, just 15% of sick children in Kaduha and 1% of sick children in Kigeme met the criteria (compared to 8% in the DHS 2010) as shown in Graph 24. However, it is important to note that this indicator does not take into account rapid diagnostic testing. Now that Rwanda is testing all suspected cases prior to treatment, it would not be expected that all sick children with fever should receive a drug – only those with a positive test. Because rates of malaria are low in Nyamagabe the MOH did not introduce community treatment for malaria until rapid diagnostic testing became available. Consequently, you would only expect a small fraction of fevers to require treatment with a malaria drug.